# Wellbeing and relationships in public policy: The officer-recipient relationship in the Oportunidades-Prospera programme in Mexico

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# Wellbeing and relationships in public policy:
## The officer-recipient relationship in the *Oportunidades-Prospera* programme in Mexico

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# Abstract

This dissertation explores the role of relationships with front-line officers on the subjective wellbeing of the recipients of the conditional cash transfer programme in Mexico, *Oportunidades-Prospera*. To do so, it builds bridges between the literatures on wellbeing, development and public policy. In recent decades, wellbeing has acquired greater significance in public policy with the interest of changing the conceptualization of progress from one driven by economic growth to one which takes quality of life as its ultimate aim. Much attention has been placed on measuring wellbeing for national policy deliberation. This dissertation, instead, is interested in understanding how taking a wellbeing approach may contribute to street-level development: to the design, practice and implementation of social policies and programmes.

The value of wellbeing is that it draws attention to dimensions of experience that policy has tended to under-estimate or ignore. In this respect, one of the most consistent findings of wellbeing scholarship is the centrality of social relationships in shaping action and driving how people evaluate their lives. While the main emphasis has been on close relationships, this dissertation asks how the relationships created during the implementation of social programmes may influence wellbeing – and hence the overall impact of policies themselves.

This research focuses on relationships at the health clinics which clients of *Oportunidades-Prospera* are required to attend as a condition for receiving a cash transfer. It follows a mixed-methods approach that reveals that relationships with health officers have a significant role on recipients' sense of what they can do and be in different domains. It also finds that the quality of these relationships has two dimensions, positive and negative, and that these have differential effects on wellbeing. The study concludes that paying attention to the wellbeing implications of officer-recipient relationships deepens understanding of the overall effect of social programmes on their clients, highlighting unintended effects that are usually unaccounted for. In addition, the significance of relationships in implementation indicates a vital dimension of the policy process that requires direct attention if social policy and programmes are to achieve their full potential to improve people's wellbeing.

# 1. Introduction

*Just as human existence is never simply an unfolding from within but rather an outcome of a situation, of a relationship with others, so human understanding is never born of contemplating the world from afar; it is an emergent and perpetually renegotiated outcome of social interaction, dialogue and engagement. And though something of one's own experience – of hope or despair, affinity or estrangement, wellbeing or illness – is always one's point of departure, this experience continually undergoes a sea change in the course of one's encounters and conversations with others. Life transpires in the subjective in-between, in a space that remains indeterminate despite our attempts to fix our position within it – a borderlands, as it were, a third world.*

Michael Jackson (2011, p.xiii)

## 1.1 Introduction

As Amartya Sen describes in his forward to Green's 2012 book *From Poverty to Power*, more than a 100 years ago George Bernard Shaw argued that "The greatest of evils and worst of crimes is poverty". Following Sen, this statement not only describes poverty as an atrocity that affects millions around the world, but as something that has a human cause. This is not to say that we can single out the criminals that place people in poverty as this is a very complex process that has a variety of causes. But it does point out to an important characteristic of poverty that can be extended to other close-connected dimensions of people's lives such as wellbeing, this is the fact that it is something created in relationship with others.

In this sense, the point of departure of this dissertation is that wellbeing should be understood as an experience constructed in interaction with others. Different kinds of social relationships mediate the resources people can have, how they can access and make use of them, and the way they feel and think about themselves and their lives. They are also key in shaping the strategies people can or cannot use to be well in different dimensions. This emphasises the necessity to place human relationships at the centre of wellbeing research and of wellbeing-driven policy-making. However, these relational processes remain understudied, especially at the level of policy. It is in this area where this dissertation makes its contribution by exploring the value of a subjective wellbeing lens in the assessment of those relationships created in the process of policy implementation, particularly, those created between front-line officers and programme participants.

In an era of evidence-based policy, the evaluation of policy success has become an area of study in its own right. However, one might wonder success in terms of what? Traditionally, policy evaluations have focused on economic outcomes and on the mechanisms of policy delivery, leaving behind human centred aspects such as wellbeing. In recent decades, researchers from different disciplines have made a strong argument in favour of relocating the person as the primary aim of policies and programmes and thus, to evaluate their success based on the extent to which they improve people's wellbeing in multidimensional terms (Stiglitz et al. 2009, Devereux and McGregor 2014, McGregor et al. 2015, Forgeard et al. 2011, Rojas 2009).

In this context, subjective wellbeing approaches emphasise that policy decision-making must pay attention to people's feelings and perspectives about their lives as they provide valuable information about what people truly value and what really matters in their personal and social life (UNDP 2012). Yet, while there is substantial agreement about the normative case of placing the person and her wellbeing as a goal of development and policy (e.g. Gough et al. 2007, Stiglitz et al. 2009, ONS 2011, OECD 2013, UNDP 2012, Rojas and Martinez 2012, McGregor et al. 2015), most efforts have primarily focused on making national and international comparisons of aggregate wellbeing reports to evaluate the general outcomes of government structures, actions or policies. In the words of the OECD (2013, p.36):

> *[B]eing grounded in peoples' experiences and judgements on multiple aspects of their life, measures of subjective well-being are uniquely placed to provide information on the net impact of changes in social and economic conditions on the perceived well-being of respondents.*

In line with this aim, numerous governments, NGOs and international think tanks have started to use subjective wellbeing to assess the state of societies. These indicators have been incorporated to large international polls (e.g. Gallup, World Values Survey, and Latinobarometro), as well as adopted by many national statistics offices (e.g. Mexico's BIARE-INEGI, UK's Measuring National Well-being, Australian National Development Index and Bhutan's Gross National Happiness; see OECD 2013 for a review), and international organizations (e.g. OECD 2013). Whilst these efforts are indeed valuable, they do not examine the links between wellbeing and policies on the ground or, as McGregor and colleagues (2015) call it, at the front-line level (see also White and Abeyasekera 2014). This implies inspecting the advantages and limitations of applying a wellbeing framework to directly design, evaluate and improve social programmes and projects. It is at this level of analysis that this dissertation is situated.

Without ignoring the importance of aggregate analyses, this 'frontline' perspective is well suited for the aim of this dissertation of examining the benefits of a subjective wellbeing approach to assess the outcomes and processes of policy implementation.

To do this, the context of the research is the largest social programme in Mexico, the *Oportunidades-Prospera* conditional cash transfer programme. There are many areas in which this programme could be evaluated from a wellbeing lens (e.g. design, agenda-setting, outcomes). However, given the cumulative evidence about the centrality of relationships for wellbeing (e.g. Ryan and Deci 2000, Ryff 1989a, Haller and Hadler 2006, White 2009, Zavaleta et al. 2014) and the fact that the 'conditionality' aspect of the programme generates constant interactions between front-line officers and programme participants, this dissertation maintains that the stage of policy implementation and the relational processes that occur within it are predominantly significant for the contribution of wellbeing.

Although this dissertation recommends the use of wellbeing in public policy more generally, it mainly concentrates on the more specific area of social policy, or those policies and programmes concerned with social welfare and social problems, and the provision of government services that address these[1]. The logic of this focus is that such policies generate and depend on the direct contact with different population groups through the work of front-line officers. Also, as certain social policies like social protection programmes and conditional cash transfers impose 'conditionality' on their benefits, this extends and intensifies the character of this interaction, making a relational perspective on social policy particularly vital.

Moreover, this dissertation identifies that although subjective approaches study social relationships by emphasising the wellbeing outcomes of close relationships (romantic, marital, family, friends or community relationships), the important sphere of policy-interactions has been largely neglected not only by public policy literature but also by wellbeing research. Yet, these interpersonal relationships need to be placed under closer scrutiny to truly enhance and understand people's wellbeing and the way it is affected by, and through, policies. It is in these regards in which the major contributions of this dissertation lie.

[1] It should also be noted that the distinction between public policy and social policy is subject to different conventions in different national traditions. In Europe, social policy is the more common term, whereas in America it is more usual to talk of public policy. In this dissertation, public policy and social policy are used interchangeably, although it is important to note that the main contribution lies in social policy specifically, as defined in the text.

A further contribution is methodological as it provides an alternative outlook to the usual in wellbeing literature. First, whereas wellbeing research tends to be dominated by quantitative methods, this dissertation undertakes a mixed-method approach, being particularly reflective of the implications of each method for how wellbeing and social relationships are understood and how these interact with each other. Second, this dissertation moves away from the usual northern samples that abound in wellbeing research by focusing on two rural and indigenous localities in central Mexico. This adds to the growing literature in development studies that explores wellbeing in the global South (e.g. White and Blackmore 2015).

## 1.2 Subjective wellbeing and public policy

Several authors have emphasised the relevance of wellbeing in policy (e.g. McGregor et al. 2015, White 2010, Stiglitz et al. 2009). For example, wellbeing offers a holistic view that avoids reducing people's lives into specific government institutions or policy aims; while subjective wellbeing specifically offers a democratic outlook as it incorporates people's own perspectives and values more directly, rather than relying on externally imposed indicators or aspects (Diener 2000, Rojas 2011).

Acknowledging the benefits of including a wellbeing framework in policy, however, does not say anything about the appropriate way to analyse people's wellbeing. In broad terms, subjective wellbeing comprises people's feelings and perceptions about their lives and their circumstances (Diener 2006). This can include people's evaluations of their lives as a whole or of different aspects such as physical health, leisure, employment, community environment, social relationships, and subjective states like mental health, affect, motivation, and purpose. Underneath this comprehensive definition, subjective wellbeing as a field of study is quite diverse (see figure 1.1 for a diagram of some of the different approaches composing the field of subjective wellbeing).

**Figure 1.1** The Subjective Wellbeing field

| **Subjective Wellbeing** | | |
|---|---|---|
| Subjective Well-being (SWB) | Psychological Wellbeing (PWB) | Psychosocial Wellbeing |
| Hedonic | Eudaimonic | |

A common way of distinguishing approaches within this field is in terms of their philosophical standpoints. Two groups can be identified in these terms, eudaimonic and hedonic approaches. Eudaimonic or also called psychological approaches (PWB) concentrate on what makes life worthwhile and meaningful (e.g. Ryff 1989a,b, Ryff and Keyes 1995, Ryan and Deci 2000, 2001), while hedonic or also called 'subjective well-being'[2] approaches (SWB) see wellbeing as the maximisation of people's happiness and the minimisation of their pains and sufferings (e.g. Diener 2006, Diener et al. 2000, Rojas and Veenhoven 2010). Both, however, primarily focus on the psychological and individual experience of wellbeing and employ quantitative and statistical tools for their study.

In recent years, another group that is not part of this classification has arisen from the separate efforts of researchers in development studies and psychosocial perspectives. Informed by a more sociological outlook, these frameworks are not only concerned about people's subjective and psychological experiences but include the material and social dimensions of life (e.g. Gough et al. 2007, White 2010, White et al. 2014, McGregor and Sumner 2010, PADHI 2009). They also emphasise more strongly the role of culture and the context in the meaning and experience of wellbeing, and promote the use of broader epistemological and methodological approaches like qualitative and mixed-methodologies. This dissertation employs this latter approach for several reasons that are justified in chapter two.

There are, nonetheless, contested matters about the employment of any subjective wellbeing approach in public policy that need to be clarified here as this dissertation does not deal with these directly. An extreme and disputed proposal is the use of subjective wellbeing as the supreme goal of policy decision-making and as the paramount indicator of the progress of societies. This stance is usually linked to the utilitarian interpretation of subjective wellbeing that takes the indicators of hedonic frameworks like happiness and life satisfaction as the main approach (e.g. Layard 2005, see UNDP 2012 for a discussion on this). However, others rightly disagree with this proposal by arguing that these approaches are inadequate for such ambitious use as they are primarily focused on outcomes while neglecting important aspects of

[2] Following the literature, to distinguish between the field of subjective wellbeing that comprises a number of approaches focusing on people's perspectives of their lives, from the specific approach within that takes this name, in here the first is referred to as 'subjective wellbeing' (without a dash) and the second as 'subjective well-being' (with a dash) or SWB.

the meaning and dynamics of wellbeing such as the processes and the normative values through which they are achieved (UNDP 2012).

Other critiques are directed to the emphasis subjective wellbeing gives to people's feelings and perceptions, the limitations of subjective indicators to capture people's true experiences and their disconnection with other aspects of wellbeing such as material needs and opportunities (e.g. White et al. 2012c). In this regard, probably the most important challenge to the use of subjective indicators is the issue of adaptive preferences mainly raised in the capabilities and human development literature (Sen 1985, Austin 2016). Adaptive preferences involve the unconscious mechanisms through which people adapt themselves and their aspirations to the circumstances in which they live. Hence, we have the cases of the depressed rich, the happy poor or the satisfied but mistreated client of a social programme. Arguably, adaptive preferences are particularly worrying in deprived groups since they may lead to the acceptance of the status quo and a diminished sense of entitlement, making wellbeing research difficult.

One could say that whereas the issue of adaptive preferences could affect certain approaches more than others - especially those that lie at the extreme of the subjective continuum (see Schwartz and Strack 1999, Diener et al. 1999) - it could be argued that in order to identify adaptive preferences, the true, valuable or authentic preferences need to be defined. This, however, involves making certain value judgements that are contrary to the philosophy of subjective wellbeing which takes as true people's own subjective feelings and experiences.

Hence, although this dissertation does not engage into these discussions difficult to settle, it takes some steps or measures to minimise possible biases and identify in different ways what people truly feel and think about their lives. Firstly, although the critique of adaptive preferences is certainly challenging to any subjective approach, this dissertation decides to take a psychosocial approach as it defends in chapter two that their outlook towards subjectivity and wellbeing - not as detached from but as embedded in time and space, in particular relational and material circumstances - is able to minimise this problem. In addition, this is combined with a mixed methods approach to obtain a deeper understanding of the self-report scores obtained through subjective indicators; and with measuring the quality of social relationships directly, giving a stronger weight to the relational processes behind subjective wellbeing experiences.

Secondly, the view taken here is that although the supreme goal of policies should indeed be people's wellbeing, wellbeing should be understood as a multidimensional phenomenon. Of course, wellbeing is not just related to people's feelings and perceptions of their lives. Objective approaches such as capabilities and basic needs are very useful complementary measures of wellbeing. Nonetheless, this dissertation strongly argues that despite the usefulness of objective measures, any wellbeing approach that aims at really placing the individual at the centre must necessarily acknowledge the importance of subjective wellbeing. Therefore, any wellbeing approach should always be used in conjunction and communication with other evaluation tools and wellbeing approaches[3]. In this sense, this dissertation follows closely the outlook proposed by the Wellbeing in Developing Countries (WeD) research group that sees wellbeing as involving at the same time material, relational and subjective aspects that can be studied at different levels and with different tools (e.g. Gough and McGregor 2007).

Thirdly, rather than advocating for the use of subjective wellbeing as a supreme and sole goal of policy, this dissertation takes a step back by emphasising that this lens brings a valuable and innovative way of evaluating the processes and implementation of policies. By giving a stronger emphasis to what people value and experience, subjective wellbeing provides a practical tool to uncover new dimensions of social programmes that contribute to better their design, implementation and evaluation. For instance, as this dissertation highlights, subjective wellbeing can help expose the significance of relational interactions in the processes of policy delivery.

## 1.3 Relationships in wellbeing and public policy

Subjective wellbeing research has uncovered and confirmed the centrality of many aspects of life for people's wellbeing across cultures that lie well beyond income. Probably the most consistent and significant has been social relationships. Indeed, most studies attest that being in relationship with others as well as the quantity and quality of relationships is essential to live well across both the life cycle and different types of populations. The significance of relationships is so strong and recurring in

[3] It agrees with most researchers who recognise the complementarity between both. For example, the capabilities approach, one of the most influential 'objective' frameworks, recognise the importance of the subjective dimension by incorporating happiness as another valuable capability and endorsing subjective measures of psychological and social capabilities (e.g. Alkire 2007, Zavaleta 2007).

wellbeing that no matter the approach and methodology employed, all agree that relationships probably are the most important contributor of a good, flourishing and happy life (e.g. Ryan and Deci 2001 offer a review). From an SWB perspective, Argyle (2001) claims that relationships are "one of the greatest sources of happiness" and Ashcroft and Caroe (2006) propose positive relationships as the most important contributor of a thriving life. From the outlook of PWB, Ryan and Deci (2001) claim "it is the quality of relatedness which engenders wellbeing" (p.155). And from the development perspective, White (2009) has suggested wellbeing is "something that happens in relationship" (p.11).

The substantial evidence provided by these studies and the prominence family and friends have for wellbeing as they have attested, has been beneficial in justifying the design of policies that promote and foster family, social and community interactions. However, focusing only on close relationships can ignore the role that programmes themselves have in creating new social scenarios that affect the programme's own successes and at the same time the wellbeing of people as they become clients of the state. One such social scenario occurs at the interface between the front-line officers that implement the programme and the final recipients.

Front-line officers constitute the most immediate link through which a policy, a social programme or a development initiative achieves its goals. They can take different forms such as physicians, nurses, counsellors, teachers, bureaucrats, or public servants. Their main characteristic is that they are the face recipients see of the programme and are the direct gatekeepers of the resources or services the programme provides. Although these officer-recipient or client-agent interactions have been explored within the medical sociology and anthropology literature particularly in health contexts[4], they are studied in the public policy literature only insufficiently and only in relation to their effects on the success of policy delivery (e.g. Lipsky 2010, Simmons and Elias 1994, Williamson and Robinson 2006). Despite this gap in the policy literature, the empirical evidence related to social programmes

[4] Since the primary concern of this dissertation is not to fully explore the specific interaction between healthcare personnel and patients but to understand relational policy processes and how they can influence wellbeing, this dissertation will not engage into a lengthy discussion of the literatures on medical sociology and anthropology and 'aidnography'. However, it will analyse some of their findings for the context of Mexico, particularly the works of Vania Smith-Oka (2009, 2012, 2014, 2015), given their geographical closeness to the research settings of this dissertation. For further information about these literatures see Green (2011), Lewis and Mosse (2006) and Venkatesan and Yarrow (2012).

around the world suggests that this relationship has important implications beyond the success of policy implementation.

In this regard, Nayaran's and colleagues (2000), for example, shows the common patterns of abuses of power, negligence, humiliation, shame and mistreatment people experience in their encounters with state corruption and the rudeness of service providers (see also e.g. Roelen 2017 and Walker and Chase 2015). These stories happen especially in developing countries and in social programmes reliant on service provision for their implementation.

> *Poor people report that their interactions with state representatives are marred by rudeness, humiliation, harassment and stonewalling. Poor people also report vast experience with corruption as they attempt to seek health care, educate their children and claim social assistance or relief assistance, get paid, or receive protection from the policy and justice from local authorities.* (p.8)

Therefore, ignoring these kinds of relationships may reduce the ability of a wellbeing approach to adequately capture the role of social policies in people's wellbeing.

This dissertation uses the insights of the development literature about the nature and characteristics of this relationship to explore their possible roles on subjective wellbeing (e.g. Wood 1985a, Shaffer 1985, Eyben 2006, 2010, Moncrieffe and Eyben 2007). These studies underscore the inherently political and hierarchical nature of this relationship. It is a relationship grounded on the authority officers are awarded by agencies; as well as on their contrasting social identities in relation to recipients in terms of gender, ethnicity, social status, and professional knowledge.

As these relationships can affect people's objective and material circumstances by restricting access to the valuable resources and services provided by the programme, the main concern of this dissertation is on their effects on the recipients' subjective wellbeing. Particularly, how the officers' forms of engagement can be wellbeing enhancing or wellbeing diminishing. This requires a wellbeing outlook able to recognise the aforementioned social, political, and cultural processes that shape this specific kind of social interaction. Hence, the appropriateness of a psychosocial approach to wellbeing. Indeed, even if social programmes and policies include a wellbeing approach in their design, the procedures of implementation can work against these holistic aims through the interface between officers and recipients on the ground if they are not directly and adequately considered.

This points to one of the main arguments in chapter two of this dissertation. Namely, the fact that distinct subjective frameworks approach wellbeing and relationships differently, which in turn, could have important implications into how they assess this specific relationship and feedback on policy implementation. Therefore, this dissertation critically compares the three key frameworks of subjective wellbeing mentioned above in these terms (Subjective Well-being (SWB), Psychological Well-being (PWB), and development or psychosocial approaches).

In broad terms, this dissertation argues that the outlooks of development and psychosocial approaches comprise an important challenge to the dominant conceptions of wellbeing and relationships offered by SWB and PWB and an ideal approach to assess officer-recipient relationships. Indeed, SWB and PWB have largely contributed to our understanding of the association between wellbeing and relationships. Yet, they implicitly and explicitly understand them as external buffers of wellbeing and their association as simply cause-and-effect. A view that ignores the more complex and intricate ways in which wellbeing and social relationships can be associated. In contrast, the proposals of critical wellbeing research in sociology, development studies and psychosocial approaches echo a more comprehensive understanding of wellbeing and relationships for the policy realm. They recognise wellbeing as something that is socially and inter-subjectively construed, actively negotiated in and through our relationships with others and influenced by larger relational processes that permeate into individual interactions like cultural values, identity formation, and power struggles.

Therefore, this dissertation mainly relies on the proposals of the Wellbeing and Developing Countries research group (Gough et al. 2007, White 2010), the Inner Wellbeing approach (White et al. 2014), and psychosocial approaches that have been developed particularly for development agencies (Galappatti 2003, Salih and Galappatti 2006, Williamson and Robinson 2006, PADHI 2009). These frameworks, while acknowledging the centrality of the material, relational and subjective dimensions of wellbeing, also emphasise the close interrelationship between these and give a stronger emphasis to relationality in the construction of wellbeing. This larger outlook not only offers a more relational understanding of subjective wellbeing, but also permits including a broader range of types of relationships beyond family and friends. This emphasis on the relational aspect of wellbeing highlights that social policies and programmes that aim at improving wellbeing are not disconnected from considerations of social relationships.

As a starting point to the analysis of the practical contribution of wellbeing in social policy on the one hand, and of the complex role of social relationships in wellbeing and policy implementation on the other, this dissertation uses the case of the *Oportunidades-Prospera* programme.

## 1.4 The context: Oportunidades-Prospera

As mentioned before, interactions with front-line officers and programme participants are central means of delivering government services and citizen entitlements in a number of sectors such as health, education, security, law enforcement and justice. However, inadequate service provision has been a major concern for governments and international organisations for many years. For instance, in 2004 the World Development Report problematized that despite being in the XXI century, public services remain inadequate for the poor in terms of reach, access, quantity and quality, especially in developing countries.

The context in which this dissertation develops is the *Oportunidades-Prospera* programme in Mexico. This is the biggest social programme in the country and probably the most renowned conditional cash transfer (CCT) in the world. This is also a very complex programme in terms of implementation as it aims at reducing the intergenerational transmission of poverty through three key components: education, health and nutrition. In practice, this implies that the programme provides bimonthly cash transfers directly to female heads of households (mothers) with the condition that they send their children to school, attend to routine health check-ups and receive workshops on preventive health care.

This research context is justified for the purposes of this dissertation since the delivery of these components is heavily reliant on front-line officers that directly interact with recipients. This happens at different stages of programme implementation: through bureaucrats during targeting and the distribution of the cash transfers, through teachers in the delivery of schooling, and through health staff in the provision of the health workshops and consultations. Conditional cash transfers like *Oportunidades-Prospera* are also ideal settings to study interactions between programme participants and front-line officers because the element of conditionality requires the constant supervision of participants' behaviours and compliance by officers themselves.

Given the size and complexity of *Oportunidades-Prospera*, it would be too ambitious to analyse the processes of implementation of the programme as a whole. Therefore, this dissertation concentrates on the health conditionality. Health is a sector that is at the centre of the development agenda. Although recently replaced by the Sustainable Development Goals (SDGs), the Millennium Development Goals (MDGs) were an important context to the establishment of the programme and to placing health as a key goal for all societies by including child mortality, maternal health, and diseases like HIV/AIDS, malaria and others in the global agenda. This involves not only increasing access but also quality of health-care services, in which interactions between officers and recipients a key mediating factor. In addition, the compliance with the health component of Oportunidades-Prospera is crucial for families to remain in the programme since its activities are strictly enforced and monitored.

The health activities that are monitored can be classified into two groups, those that are formally stipulated by the programme and those that have been informally developed and used for the administration of the health procedures. The official conditions involve attending to monthly health workshops directed to mothers and complying with regular family medical check-ups, aside from the regular appointments when a member of the family falls ill. The informal conditions require participants to perform what could be described as unpaid jobs under the supervision of health officers. These can include tasks such as cleaning and conducting maintenance work at the clinic and in local public places, as well as participating in health campaigns. These informal conditions, however, are not stipulated nor regulated by the programme. Therefore, they can have important implications on the nature and quality of the interaction between officers and recipients by bringing a new set of hierarchies to a relationship that, arguably, is already charged with issues of power, authority and forms of control that are potentially problematic for wellbeing.

In conjunction, the formal and informal conditionalities generate repeated and long-lasting interactions between programme participants and health officers that could neutralise the potential outcomes of the programme over its direct aims and over the wellbeing of recipients. Hence, this dissertation critically explores current programme evaluations and empirical research on the challenges of the quality of health care provision in Mexico and in the programme (e.g. Gutiérrez et al. 2008, Adato et al. 2000a, Skoufias 2005, Álvarez et al. 2008), as well as the role of the attitudes and behaviours of health officers for overcoming them (e.g. Gutiérrez et al. 2008, Sánchez-López 2008, Agudo Sanchiz 2012, Campos 2012, Smith-Oka 2013).

In addition, this dissertation identifies that despite the large volume of research and evaluations of the programme, they have failed to evaluate the success of the *Oportunidades-Prospera* programme in two ways. Firstly, from a subjective wellbeing perspective and secondly, from a process perspective emphasising the relationality that is created during implementation. Although the relational processes of policy implementation are increasingly included in wellbeing focused evaluations (e.g. Devereux et al. 2013) and 'small n' methods of evaluation (e.g. Cargo and Warner 2013), traditional evaluations have largely concentrated on objective programme outcomes such as school attendance, compliance with the health conditionalities, increases in nutrition levels and decreases in morbidity rates. These objective outcomes, nonetheless, provide insufficient information about what people can achieve with them, exclude people's perceptions of the programme and neglect programme processes at the level of implementation that can have an important effect on people's wellbeing. They disregard the social processes that can contribute to keeping people in deprived situations and the extent to which the programme reinforces or challenges these relational constraints during implementation.

Therefore, the suitability of the research context lies in the fact that little attention has been paid to a more holistic understanding of people's wellbeing experiences during their interface with this social programme and its implementation procedures. This dissertation intends to analyse one aspect of this: how programme's processes and implementation mechanisms conducted by front-line officers can transform the outcomes of the programme in wellbeing terms, by enhancing or diminishing the wellbeing of recipients.

## 1.5 The purpose of this dissertation and research questions

The overall purpose of this dissertation is to examine how a subjective wellbeing lens can improve public policy on the ground by looking at the relationships created during policy implementation and their wellbeing implications.

The main research question that this dissertation poses is:

1. In which ways can a subjective wellbeing approach contribute to assess and evaluate policy processes?

This is examined through the following questions:

2. What are the characteristics of officer-recipient relationships in the delivery of the health conditionality of *Oportunidades-Prospera*?
3. What is the shape of the subjective wellbeing of recipients?
4. What is the role of officer-recipient relationships in the subjective wellbeing of recipients?

These interrogations are answered through a mixed-method approach following emerging call from public policy (e.g. Adato 2007, Ravallion 2009, Kanbur and Shaffer 2005) and wellbeing research in development studies (e.g. White et al. 2016, Roelen and Camfield 2015, Camfield et al. 2009b, Jones and Sumner 2009). Yet, although mixing methods have been largely advocated, the practical challenges of its application in developing contexts and the communication between quantitative and qualitative results is still under exploration. This dissertation enters this discussion from the specific angle of the analysis of subjective wellbeing and social relationships created in policy contexts.

Within this overall methodology, evidence for this research comes primarily from surveys, interviews and focus groups with recipients and interviews with health staff. Other sources used are direct observation of programme implementation at the local health centres. The qualitative and quantitative data are used to answer all research questions. Therefore, the aim of mixing is one of complementarity and elaboration. Both methods are considered to provide equally valuable information and their results are analysed in their own right while pondering their agreements and disagreements.

This research is conducted in two localities situated in the state of Puebla, one of the poorest and most unequal states in the country. The sites, called here Nexpan and Cualcan, are chosen for their contrasts in terms of proximity to urbanization and ethnicity that potentially influence officer-recipient relationships. Nexpan is a semi-rural and mestizo locality at the outskirts of the large metropolitan area around the capital city of the state. Cualcan, in contrast, is a rural and indigenous community located in the mountain range of the state.

Specifically, in giving answer to the research questions, this dissertation discusses three key issues for wellbeing research and policy guidance. Firstly, while the issue of whether officer-recipient relationships can alter the course and effectiveness of the programmes has been largely answered (e.g. Bold et al. 2012), this dissertation

focuses on showing how this happens. Particularly, on assessing how the relational policy processes that occur during this specific relationship can transform the wellbeing of programme participants. Secondly, whether taking a broader outlook towards social relationships and subjective wellbeing contributes to better understand their complex forms of association, some of which are particularly relevant in a policy scenario. Thirdly, whether mixed-methods provides a useful lens for the study of these complex phenomena, and what are the contributions and challenges of bringing different forms of evidence together. Ultimately, this dissertation explores in which ways a subjective wellbeing approach contributes to assessing and uncovering the relational processes of policy implementation that are usually unaccounted for by traditional evaluations.

## 1.6 The outline of the chapters

Chapter two presents subjective wellbeing as a field of study and critically examines the conceptual and methodological approaches to social relationships of the dominant frameworks of SWB and PWB on one hand, and the wellbeing approaches in international development and sociology on the other. It also analyses what is currently known about the nature of officer-recipient relationships in the public policy literature, emphasising processes of power, discretion, social exclusion, labelling and identity differentiation that call for the broader wellbeing framework offered by the approaches in sociology and international development.

Chapter three focuses on the *Oportunidades-Prospera* conditional cash transfer (CCTs) programme and the implementation of its health component. In addition to introducing the programme in relation to social protection programmes and CCTs as a whole, this chapter explains why it is an ideal scenario to study the role of officer-recipient relationships on subjective wellbeing. It also analyses most well-known evaluations and studies on the programme, and highlights the need for further research on potential wellbeing implications of this relationship. Ultimately this chapter defends looking at this relationship and its effects for wellbeing as it could show critical unaccounted consequences of social programmes for people's lives.

Chapter four develops the research design and methodology of this dissertation. It defends the use of mixed-methods as the methodological framework, critical realism as the ontological and epistemological approach and the Inner Wellbeing (IWB)

model as the conceptual framework for studying wellbeing. This chapter also explains the research strategy undertaken, that is, the sample and sampling procedures, the aims of the qualitative and quantitative studies, and the ethical considerations.

Chapter five is the first empirical chapter of the dissertation, which starts with the qualitative findings. This chapter focuses on the qualitative results obtained from the period of observation and from the interviews conducted with seven health officers of the programme in two different localities. It examines through discourse analysis the officers' descriptions of recipient families, of their relationship with recipients, and of the roles of both in the implementation of the programme and in the procedures of the clinic. This chapter serves to characterise the relationship and the larger processes that shape it.

Chapter six instead focuses on the narratives of recipients about their experiences during the implementation of the health component of the programme, how they characterise their relationship with physicians and nurses, and the channels through which this relationship can influence wellbeing. The analysis is organised by locality, and is based on the 30 interviews and two focus groups performed with recipients, and the observations conducted in the clinics.

Chapter seven introduces the quantitative analysis of this dissertation. It describes the sample and the data set collected in each locality, as well as the statistical construction and consistency of the Inner Wellbeing (IWB) domains and of the quality of the relationship with officers (QoR[5]) scale through factor analytic procedures. This chapter (as the rest of the empirical chapters) also discusses the conceptual and methodological implications of the final form taken by the scales in this sample, particularly their implications for the study of wellbeing and relationships, and for mixed-methods research.

Chapter eight is the last empirical chapter of this dissertation. It presents the quantitative investigation of wellbeing, relationships with officers and of their association, responding to the three sub-questions of this research. Specifically, this chapter describes the behaviour of QoR and IWB across the sample through descriptive and inferential tools, and examines the association between IWB and

[5] This dissertation uses the QoR abbreviation only to refer to a particular kind of relationship, the quality of the relationship with programme officers.

SWB, as well as the relationship between QoR and IWB, through correlation and regression analyses using Ordinary Least Squares (OLS) and Probit models.

The empirical chapters present the qualitative and quantitative data separately and sequentially, however, each chapter engages in a discussion about the conceptual and methodological implications of the findings - particularly those for the study of wellbeing and relationships, and for mixed-methods research. As a result, chapter nine presents the discussion and the conclusion of the dissertation in conjunction. It brings together the findings of the qualitative and quantitative data and critically examines how both methods contribute to answering the research questions and to what extent they reflect what was expected from the literature review. This chapter also offers the theoretical, methodological and policy contributions of this research project and ends with the limitations and the recommendations for future research.

# 2. Relationships in wellbeing research and their utility for public policy

## 2.1 Introduction

Subjective wellbeing is now widely accepted as a significant measure of the success of international development and public policies, as goals broaden from a focus simply on people's income or national GDP to creating the circumstances for human wellbeing and happiness. Yet, as claimed in the introduction to this dissertation, researchers are still exploring the practical implications of subjective wellbeing for policy design, evaluation and analysis. This chapter takes steps in this direction by underlining the importance of taking into account relationships and wellbeing processes during programme implementation, particularly those at the final stage of the policy process, between front-line officers and programme participants.

The primary purpose of this chapter is, therefore, to argue that these relationships must be evaluated if a wellbeing approach is to be effective in orienting and evaluating social programmes and informing policy. This is done by examining how mainstream and critical research on subjective wellbeing have conceptually and empirically studied social relationships. Although all approaches have shown the overarching effect of social relationships on wellbeing, this chapter argues that relationships between officers and recipients have certain characteristics that are non-negligible for wellbeing and that require the broader lens provided by critical research on subjective wellbeing, mainly development and psychosocial approaches.

The chapter is structured as follows. Section 2.2 starts by identifying the contributions of a wellbeing lens to public policy, and then explains key characteristics of subjective wellbeing as a field of study and the main differences between the most well-known approaches. Section 2.3 then identifies that the dominant approaches to subjective wellbeing, regardless of their differences, have obtained consistent findings about the primacy and overarching significance of social relationships to wellbeing. At the same time, this review discusses some of their conceptual and methodological limitations that are potentially relevant to observing social relationships in the policy realm. Relying on broader literature on client-agent interactions in development, section 2.4 further justifies these limitations by presenting what is currently known about the nature and characteristics of intervention-associated relationships. These studies underscore the role of power and identity on the dynamics of this relationship, issues that are not widely studied nor measured in mainstream wellbeing research.

After reaffirming the centrality of relationships in wellbeing and their usefulness to improve public policy, section 2.5 highlights the need of taking a broader approach to

better account for intervention-associated relationships through a wellbeing lens. To do this, it relies on the broader outlook offered by wellbeing approaches in international development, sociology and psychosocial perspectives. These approaches underscore and permit observing not only the outcomes of interaction, but also the complex processes through which relationships can co-construct how wellbeing is experienced during policy interventions.

Ultimately, this chapter describes what is already known about the association between social relationships and subjective wellbeing. It then identifies the strengths and weaknesses of the current wellbeing literature for exploring intervention-associated relationships. Finally, it proposes some key questions and tools to guide the analysis of relationships in policy contexts from a wellbeing perspective.

## 2.2 Wellbeing in public policy

For a long time, there has been a strong identification of development with economic growth. At national level, Gross Domestic Product (GDP) has been the most used indicator of policy effectiveness, societal progress, and even as a proxy of people's wellbeing (Blanchflower 2008). However, through time, it has become apparent that this equivalence is raised upon many wrong assumptions about the capacity of income to improve quality of life and to reduce illbeing and poverty (e.g. see Stiglitz et al. 2009, Constanza et al. 2009 for reviews). The challenges of using measures of income for purposes they were not initially designed to fulfil, thus, initiated a search for a better-suited framework to capture the complexity of people's lives.

The notion of wellbeing provides such an alternative framework. In the last decades, the question about what wellbeing is and how can it be observed has prompted significant theoretical and empirical research from a diversity of disciplines. This makes offering a broad sketch of the field a challenging task, not only because of the multiple disciplines involved but also because of the number of possible ways to distinguish between wellbeing approaches (see e.g. Gasper 2010, White 2015, Dolan et al. 2006, and Phillips 2006 for different takes on this)[6]. Despite the diversity of approaches, nowadays there is increasing consensus about the benefits of wellbeing as an alternative approach to social progress. Although the Stiglitz-Sen-Fitoussi

[6] Possibly the simplest classification is that which distinguishes between a focus on objective and subjective dimensions (see e.g. Gasper 2010, White 2015).

Commission is probably the most cited report on this regard (Stiglitz et al. 2009), the list of academics, governments, organizations and think tanks endorsing wellbeing – even if from different standpoints - is much longer (e.g. Sen 1999, Rojas and Martinez 2012, ONS 2011, OECD 2013, McGregor et al. 2015, Layard 2009, Forgeard et al. 2011, Cummins 2009, Helliwell et al. 2013, UNDP 2012).

In accordance with this movement, this dissertation maintains that wellbeing is indeed essential for our understanding of development and for guiding public policies for several reasons. Overall, it involves a shift in priorities. It explicitly places the person at the centre-stage and it proposes to evaluate progress, policies and programmes based on whether they ultimately contribute to generating the conditions for people to enjoy a good life (Rojas 2009, 2014). Wellbeing also offers a holistic view of human life, recognising that our ability to live well is complex and shaped by experiences and achievements in a number of areas of life. In public policy, this multidimensional lens challenges tendencies to operate in disciplinary or bureaucratic silos. It also implies moving away from only evaluating the efficacy of policies based on their a priori established outcomes to explore unintended or overlooked consequences for other spheres of people's lives.

Finally, wellbeing also offers a positive language and mindset that is seldom used within public policy and development, which have traditionally centred on the negatives, on what people lack or suffer such as poverty, unemployment, and mental or physical impairments (White 2010). Although it is imperative to deal with life's negative aspects - especially of the most marginalised and excluded - having these as the only focus runs the risk of deepening the gap between those doing 'well' and those doing 'poorly', as well as reaffirming negative labels and judgements that can carry social stigma (ibid).

A wellbeing approach, therefore, reduces the tendency to divide people's lives according to specific spheres, governmental institutions or policy aims. It represents a conceptual unifier across distinct sectors of policy-making, even pointing towards areas of policy consideration that have not been sufficiently taken up by governments (White 2010, McGregor and Sumner 2010). For this reason, there are numerous initiatives taking a wellbeing approach in public policy (see UNDP 2012 for an extensive review). McGregor and colleagues (2015) identify two levels at which these policies are applied, national and front-line.

The calculation of wellbeing indices at national level to compare across nations has played an important part in getting wellbeing onto the political agenda. The construction of robust measures has been critical in making the argument that wellbeing should influence public policy debates. In addition, wellbeing approaches have been recommended to evaluate front-line social programmes and development initiatives particularly from the discipline of development studies (e.g. McGregor et al. 2015, White 2014, Devereux et al. 2013, Molyneux et al. 2016). This implies using wellbeing findings and tools for designing, orienting and evaluating the outcomes and procedures of social programmes that have direct contact with the general population and vulnerable groups. This dissertation contributes to this developing area. Focusing on the interactions between clients and front-line officers, it seeks to understand better how a wellbeing lens can contribute to the understanding of the effectiveness of social programmes and analyse their procedures, practices of implementation and ultimate objectives from a human-centred perspective.

This section has argued that wellbeing has gained public and political acceptance and thus it is time to make the transition towards a wider agenda for public policy (Rojas 2009, Devereux et al. 2013, Devereux and McGregor 2014). So far, however, wellbeing has been used as an all-encompassing term without paying attention to differences in the ways it is conceptualised by distinct subjective approaches. These are therefore delineated in the next section.

### 2.2.1 Subjective wellbeing

Diener (2006, p.400) provides a comprehensive definition of subjective wellbeing as "an umbrella term for the different valuations people make regarding their lives, the events happening to them, their bodies and minds, and the circumstances in which they live". The case for subjective wellbeing in policy is based on two main arguments: first, that it constitutes valuable information for assessing how individuals and societies are doing, and second, that how people think and feel about their lives can be reliably measured (e.g. Stiglitz et al. 2009, Rojas 2007, Devereux and McGregor 2014, Gough and McGregor 2007, Diener 2006, Cummins et al. 2009).

Yet, the value of this approach to wellbeing in policy is still contested. Critiques relate to the difficulty of making cross-cultural comparisons (Diener and Suh 1999, Christopher 1999); the proximate factors that influence subjective evaluations, such as social desirability bias, social comparison bias (Kahneman and Tverskey 1984)

and adaptive preferences (Frederic and Loewenstein 1999, Gasper 2007) (see Gough et al. 2007, Stiglitz et al. 2009 for general discussions on these limitations); and the adequate use of subjective indicators by governments (Frey and Stutzer 2012). Some argue that subjective wellbeing should not be a policy goal because it is highly dependent on personal characteristics such as personality traits or genetics. Hence, the responsibility for subjective wellbeing should remain at the individual level (see Wilkinson 2007). However, evidence suggests that subjective wellbeing is not only determined by internal or personal aspects, but also by the external social circumstances and capabilities of the person, which remain a key area of influence of public policy and governments (UNDP 2012).

While some still contend that externally verifiable, objective measures are the only sound basis for public policy, researchers on social indicators have been testing self-report indicators for monitoring society since the 1960s (see Zapf 2000). Initially this involved collecting people's accounts of their external conditions, for example evaluating their perceptions of safety in their neighbourhoods or the state of the national economy. They may also include more social dimensions of people's experience, such as their agency, participation in communities and the quality of social relationships. However, the distinctive kind of subjective questions are those that measure aspects of life that do not have an "obvious objective counterpart" and thus cannot be externally assessed (Stiglitz et al 2009, p.43; e.g. Andrews and Withey 1976). These include question about the balance between positive and negative emotions or satisfaction with life[7].

Is important to note that although some of these subjective reports might have objective counterparts, these should not be mistaken as equivalents since the latter sometimes can be misleading or partial. Hence, the evidence until now suggests that while the possibility of measuring subjective wellbeing has been the focus of considerable debate[8] and space to improve them surely remains, there is increasing agreement that "is possible to collect meaningful and reliable data on subjective [wellbeing]" (Stiglitz et al. 2009, p.16, see also Rojas 2011 and Veenhoven 2002).

The adoption of subjective wellbeing measures in policy involves changing not only (1) what is measured but also (2) by whom it is measured. They move away from

[7] The Wellbeing and Poverty Pathways Briefing No. 1 provides a useful analysis of the layers at which objective and subjective dimensions can be measured. This is also discussed in White and Abeyasekera (2014).
[8] Some of which are discussed in chapter four.

objective indicators of people's life circumstances, which are taken as a proxy for their quality of life, and concentrate on a more direct form of assessment, what people say they think and feel about their lives. In theory, at least, this places people themselves at the centre of the assessment of wellbeing, although often the choice of measures and analysis remain in the hands of experts. Subjective wellbeing thus has the potential to offer a more democratic form of evaluation.

The need for a democratic form of evaluation that centres on the people that policies seek to benefit is especially pressing in the case of poor, vulnerable and diverse populations "who are usually excluded or disenfranchised in elite-dominated policy processes" (McGregor et al. 2015, p.2). In these contexts, moving away from taking an objective-external approach to wellbeing and instead listening to people's own voices is invaluable because it reduces the elite bias of many policies. This in turn lessens the risk of inappropriate design, implementation and evaluation of policies and programmes. Hence, although improving subjective wellbeing should not be considered the sole goal of public policy, it does provide a valuable dimension that is useful for policy-making and evaluation.

### 2.2.2 SWB, PWB and psychosocial approaches

The field of subjective wellbeing is however varied. It has been developed in the intersection of many social disciplines - economics, psychology, and sociology primarily - resulting in not one but a number of approaches. Three clearly distinguishable strands within the field are subjective well-being (SWB) [9], psychological wellbeing (PWB), and more recently psychosocial or development approaches. While each of these agrees on the importance of relationships, relationships are differently incorporated in their conceptual and methodological corpus, which could have diverse implications for the design, evaluation and analysis of policies. Hence, a brief description of these distinct approaches is needed.

Firstly, SWB has its roots in the ancient belief that a good life is that in which experiences of pleasure outweigh experiences of pain. This is linked to a hedonic understanding of wellbeing and a utilitarian view of the maximization of happiness (Diener 1984, Diener and Lucas 2000, Diener et al. 1999). While SWB itself

[9] As mentioned in chapter one, this dissertation distinguishes the area of subjective wellbeing and the particular approach that takes this name, by referring to the former as 'subjective wellbeing' and to the latter as 'subjective well-being' (SWB).

comprises a range of frameworks[10], it is commonly seen as a compound of two psychological spheres: *cognitive* and *affective* (Diener 1984, Rojas and Veenhoven 2010). A*ffect* is mainly concerned with "what makes experiences and life pleasant and unpleasant" (Kahneman et al. 1999, p.ix). It denotes feelings and emotions that are associated with people's reactions towards life circumstances (Diener 2006). In contrast, *cognitive* evaluations can resemble the weighting of the pros and cons of one's life and require a mental effort to recollect past experiences (Stiglitz et al. 2009). These can be made for life as a whole (Diener et al. 1985, Veenhoven 2009b) or separated by domains (Diener et al. 2000, e.g. Cummins 1996, van Praag et al. 2003, Rojas 2006, 2007a)[11].

In practice, SWB is predominantly quantitative – people are asked to rate their lives according to a number on a scale. SWB thus stands at one extreme of the subjective continuum as an empirically-driven approach that does not depend on any explicit theory of wellbeing nor make any judgement about the basis on which people make their evaluations (Diener 2000). The features of its chief measures, the single-item global indicators of Life Satisfaction and Happiness[12] can illustrate this since they capture people's overall evaluations of their lives into an abstracted, single number (Diener and Suh 2000). Hence, instead of defining the components of wellbeing theoretically, SWB researchers identify them through inferential analyses and through the selection of certain explanatory variables in each context or study. This process can result in finding distinct determinants of wellbeing from one context to another.

Therefore, SWB can be understood not as a theory of wellbeing but as an empirical tool that can be used by a number of disciplinary areas and in public policy for international rankings of wellbeing. Indeed, their simplicity has meant that SWB indicators have been the most widely used measures, employed by a wide variety of

[10] These can include Subjective Well-being (SWB) (e.g. Diener 2009, Rojas 2004b, Helliwell et al. 2016) and Economics of Happiness (Easterlin 2004, Frey and Stutzer 2002, Bruni 2008). Even if there are differences between these, this dissertation is not concerned with analysing these in detail. Rather, it highlights common features that impinge on their analysis of wellbeing and relationships.

[11] SWB proposes capturing these through various quantitative tools, including global questions of happiness and life satisfaction (Diener et al. 1985), the balance of affective states (Diener 2006, Veenhoven 2010, Diener and Suh 2000); as well as through satisfaction with specific domains (Diener et al. 2000, Cummins et al. 2009, Rojas 2004a).

[12] The 2010-2014 wave of the World Values Survey used the following versions. For happiness: "Taking all things together, would you say you are, very happy (1), rather happy (2), not very happy (3) or not at all happy (4)". For life satisfaction and following a 10-point Likert scale: "All things considered, how satisfied are you with your life as a whole these days?" The wording and scales vary between studies.

researchers and governments (see OECD 2013 for a review of countries using versions of these indicators).

The second major approach, psychological wellbeing (PWB) (Ryff 1989a,b, Ryan and Deci 2001) has its origins in Aristotle's understanding of the good life as something that can only be found in virtue, meaningfulness, and the expression of human potentials. This maintains that equating wellbeing to feeling happy is dangerous, since what makes you happy might not promote a flourishing life but instead have negative long-term effects (Ryff 1989a, Ryan and Deci 2001). As a result of these philosophical foundations, PWB is usually characterised as eudaimonic wellbeing. Probably the most salient among psychological approaches are the model of Psychological Well-being (Ryff 1989a) and the Theory of Self-Determination (Ryan and Deci 2000, Deci and Ryan 2000).

The common characteristic between PWB approaches is that they conceptualise wellbeing as composed of a set of defining domains or components based upon theoretical research about what is entailed in a life with purpose and meaning. For instance, the construction of Ryff's model began with a revision of various frameworks within the humanistic tradition of psychology, including research on personality, developmental and mental health theories (Ryff 1989) and notions of positive functioning (Ryff and Keyes 1995). The outcome was a six-domain model composed of autonomy, positive relationships with others, environmental mastery, personal growth, purpose in life, and self-acceptance (see Ryff and Singer 1998, Ryff 1995). In line with its eudaimonic foundations, all domains are important, necessary, and irreducible for experiencing wellbeing. They *constitute* the essence of good living in every context and culture. Eudaimonic approaches thus propose universal models of wellbeing.

Both SWB and PWB approaches, however, have been criticised for their cross-cultural applicability, which might be problematic when applied for policy guidance in particular contexts. For example, the claim that SWB is value free has been challenged on the grounds that it assumes a particular, individualised cultural understanding of the person (Christopher 1999, White 2015). This criticism is also levelled at PWB, where the choice of domains - particularly in Ryff's model – appears to be bound to certain cultural understandings of wellbeing. In addition, PWB has

been criticised as top-down for the predominance of theory and the role of experts in establishing its domains (e.g. Diener et al. 1998; Rojas 2011, 2014)[13].

The third and most recent strand is composed of a myriad of psychosocial and development approaches that are influenced more strongly by sociology (e.g. Gough and McGregor 2007, White et al. 2014). The interest in quality of life and poverty has existed in the development literature for a long time. Since the 1980s, the works of Robert Chambers (1983) and others have proposed substituting top-down approaches with participatory tools that assess how people and their communities are doing. Since then, formal approaches to wellbeing have been established. These include the Wellbeing in Developing Countries (WeD) research group (e.g. Gough et al. 2007), the Wellbeing and Poverty Pathways research project (WPP) (White et al. 2014) and the psychosocial frameworks that arose in the context of humanitarian initiatives (Salih and Galappatti 2006, Williamson and Robinson 2006, UNICEF 1997).

A major distinction of this research compared with SWB and PWB is the call for moving beyond relying primarily on quantitative indicators and for embracing qualitative and mixed methodologies (e.g. Camfield et al. 2009a, Jiménez 2008, Calestani 2009, Fisher et al. 2014, Gough et al. 2007, White et al. 2014). The subjective here is not conceptualized solely as an inner experience, instead, researchers make explicit the influence of culture, values, social norms and social interactions in shaping those inner and subjective evaluations in given contexts. As McGregor and Sumner (2010) argue, the subjective involves the "meanings that people give to the goals they achieve and the processes in which they engage" (p.105). Hence, a defining feature of this strand is that although they maintain the emphasis on the person and her perspectives, they detach from the internal and psychological orientation of the approaches reviewed above by underlining that preferences, aspirations and perceptions are grounded and negotiated in culture and social meaning (White 2010). They also prioritise assessments of wellbeing in and for contexts of development, poverty and/or humanitarian crisis.

As is possible to see from this brief review, subjective wellbeing is a diverse field comprising significant differences in terms of concepts and methodologies. These differences are likely to have implications for how social relationships are studied and their usefulness for development and public policy guidance. In fact, the way each

[13] These issues are discussed in more detail in chapter four.

approach treats relationships constitutes a particularly telling marker of the distinctions between the approaches. The next section presents some of the key findings that attest the overarching and complex importance of relationships for wellbeing. This review starts with the main discoveries within the dominant approaches of SWB and PWB, problematizing their usefulness for the policy realm and leads to the argument that psychosocial approaches may be better suited for this context.

## 2.3 The overarching significance of relationships and the limits of SWB and PWB for public policy

There is a huge literature on social relationships reflecting a long history across several disciplines. From an evolutionary perspective, the gregarious nature of human beings provides substantial support for the centrality of social interaction for our survival and development. The empirical study of social relationships' association with wellbeing has expanded in recent decades (La Guardia and Patrick 2008) and the centrality of social relationships across the life cycle, cultures and types of populations is one of the most consistent findings. Within this literature, the main themes studied have been relationship satisfaction, the relative significance of quantity or quality of relationships, key features of relationships such as support, reciprocity, attachment, intimacy, and interdependence, and their impact on wellbeing (see Baumeister and Leary 1995, Haller and Hadler 2006, La Guardia and Patrick 2008 for reviews).

Across the diversity of approaches there is general agreement that social relationships are both instrumentally and intrinsically valuable to live well. Their instrumental value captures the ability of relationships to be resources or means for obtaining benefits. The social capital, social cohesion and social exclusion literatures have contributed much to our understanding of this aspect, underscoring how relationships can promote or hinder people's ability to deal with economic crises, obtain employment and access resources and services[14] (e.g. Putnam 2000; for a review of the literature see Zavaleta et al. 2014).

[14] These literatures have primarily studied social relationships through objective indicators. Hence, this dissertation does not directly engage with them since the interest lies in understanding how social relationships are associated with people's own life evaluations.

However, relationships are not only instruments to acquire external things, but also enable people to feel safe, secure and supported. For instance, researchers have found relationships to be key vehicles to cope with stressful situations (Collins and Feeney 2000, Stratton 2007), as well as to gain a sense of safety (Downie et al. 2008). Cohen (2004) reviews some positive implications of social relationships, including positive health outcomes such as reducing the risk of mortality, the incidence of some degenerative illnesses, anxiety and depression, as well as reducing the effects of material and economic difficulties (see also Cummins 2005, Diener and Seligman 2002, Myers 2000, Camfield et al. 2009a, Rojas 2007a). For the case of Mexico, Rojas (2007a) showed that the difference in overall life satisfaction between poor and non-poor is much lower than the difference in income particularly because of the effects of relationship satisfaction (see also Camfield et al. 2009a for Bangladesh).

In contrast, the intrinsic significance of social relationships underscores that relationality is good in itself. That is, having social contact, enjoying positive relations with others, experiencing a sense of belonging, and being able to participate in society is intrinsically valuable for living well (e.g. Ryan and Deci 2001). Arguably, however, the literature on subjective wellbeing has primarily focused on relationships as means to wellbeing, providing consistent evidence that being married and involved in social, community and religious activities increases happiness, life satisfaction and psychological wellbeing (Haller and Hadler 2006, Layard et al. 2012, Cummins et al. 2009, Krauss and Graham 2013, Inglehart 1990, Myers 2000). Having social contact can promote a sense of belonging (Morrow 2001) provide emotional support, care and companionship (Demir and Weitekamp 2007), and is a main motivation for engaging in activities such as employment, participating in church or sports clubs, and even taking time for leisure (Argyle 2001). These results have been confirmed in several cross-cultural studies using both qualitative and quantitative methodologies (e.g. Camfield et al. 2009a).

Relationships are explored by wellbeing approaches at different levels, however. Probably the most superficial level is exploring the role of 'having or being in relationships' on wellbeing which is usually taken up by SWB approaches. For instance, Haller and Hadler (2006) conducted a large multinational and multilevel regression analysis investigating the association between social relationships and structures on happiness. At the micro-level, the authors included four 'relationship

However, in many cases their findings and measures are used in wellbeing studies, and thus are indirectly explored here.

variables' that can be considered proxies of having close relationships and social networks: marital status, having children, religious participation and membership of voluntary associations. Besides finding that people who are part of a family (are married and have children) and participating in social activities are significantly happier than those who do not, a noticeable characteristic of this study is that their relationships measures only assess the existence of social ties, probably the simplest level of association between social relationships and wellbeing.

There is, conversely, no consensus in the literature about the importance of the quantity of social relationships for wellbeing. Quantity is generally understood as the number and frequency of interactions with others (Zavaleta el al. 2014). These can be family, friends, social or religious groups we belong to, and some studies even include weaker ties such as acquaintances. Most have found evidence that people are less lonely, have a greater sense of belonging and report more positive affect on days they socialize more with close others (Vittengl and Holt 1998, Wheeler et al. 1983, Reis et al. 2000) and even with distant acquaintances like government officers or service providers (Sandstrom and Dunn 2014). In a study conducted with university students and community members in British Columbia USA, Sandstrom and Dunn (2014) found that when people had more daily interactions with weak ties such as classmates, work colleagues, or a barista at a coffee shop, they reported greater feelings of belonging and happiness.

Other studies have maintained, however, that the frequency and quantity of our social interactions are non-significant or even negative for wellbeing (Demir and Weitekamp 2006, see Nezlek et al. 2002 for a review). Nezlek and colleagues (2002) argue that a possible reason for such contradictory results might be the variety of factors involved in the number of interactions one has. For example, having infrequent interactions with others can be the result of a personal choice that can nonetheless increase wellbeing. Another possibility is that while these results do say something about the importance of avoiding social isolation for wellbeing, they do not say much about how the quality of these relationships (e.g. how supportive they are) might contribute differently to subjective wellbeing.

Going beyond these studies that merely focus on the impact of the presence or absence of relations, another consistent finding is the strong influence of the quality of our social relationships for wellbeing. However, SWB and PWB approaches have explored quality in different ways. SWB has explored quality primarily through the domain satisfaction approach, which measures quality indirectly through an indicator

about the reported level of satisfaction with relationships (Diener 1984). In this literature, life satisfaction partly depends on satisfaction with concrete areas of life in which social relationships is one of them (Rojas 2006). In fact, relationships appear in most models of domain satisfaction, but in different forms, such as partner, children, friends and community (e.g. Cummins 1996). The majority of empirical studies have found, however, that close relationships are one of the most important domains in a diversity of contexts, and thus, most (if not all) studies of domain satisfaction include them (e.g. Argyle 2001, Headey and Wearing 1992, Rojas 2006).

Rojas' (2006) large-scale study in Mexico City is an example of this kind of study. It focused on understanding the determinants of life satisfaction in this context, including three domains of relationships - family, friends and community environment - among several other satisfaction questions. In a further study, Rojas (2007b) concluded that in this context, satisfaction with partners, children and family in general has the strongest effect on happiness above health, job, and economic satisfaction. The distinctive characteristic of this approach is that it tries to obtain more information about relationships by asking participants to rate their satisfaction with different types of relationships. This implies evaluating the perceived quality of relationships without defining what quality actually means. This is in line with the aim of SWB of avoiding making any theoretical assumptions about the 'good life'.

However, this approach might be insufficient when assessing relationships in policy contexts. For example, Simmons and Elias' (1994) article on client-provider interactions finds that quality of interactions and satisfaction with interactions do not necessarily vary together. The authors discovered that high levels of satisfaction with social interactions occur even when the quality of interactions during service provision is inadequate. This discrepancy, they claimed, is especially salient in developing countries probably because of greater social inequalities and a context of constant inadequate treatment. This, of course, raises a debate that is difficult to resolve about the tension between leaving in the hands of the person the decision about what a good relationship entails and defining more precisely what counts as a good interaction based on theoretical and empirical research. Eudaimonic approaches (PWB) propose taking the latter procedure by assessing quality based on how flourishing and meaningful relationships are using previous psychological research.

Indeed, eudaimonic approaches have built on years of knowledge from psychologists who have explored the qualitative attributes of a relationship. In this task, concepts like trust, commitment, attachment, sense of belonging, intimacy, support, and

security have emerged as especially relevant (Baumeister and Leary 1995, Reis and Patrick 1996, Reis et al. 2000, Ryff and Singer 2000). For instance, in 1995 Baumeister and Leary proposed the 'belongingness hypothesis', which stated that 'human beings have a pervasive drive to form and maintain at least a minimum quantity of lasting, positive and significant interpersonal relationships" (p.497). This suggests that the importance of relationships in people's lives entails more than simply having social contact with others but also that these relationships have certain qualities.

Eudaimonic approaches, thus, include a domain of the quality of social relationships in their models. For instance, the domain of Positive Relations in Ryff's model of Psychological Well-being is defined as having warm, intimate, supporting, and trusting relationships, as well as experiencing feelings of empathy and affection for others (Ryff 1989a, Ryff and Keyes 1995). Therefore, this domain not only captures the significance of quality but of reciprocal relationships in which receiving as well as giving contributes to wellbeing.

In turn, for SDT enjoying a sense of belonging and attachment in our relationships is a basic psychological need captured in the need for relatedness. Relatedness is defined as feeling connected to and developing close relationships with others, this includes need to belong, be cared for, and have a sense of security (Baumeister and Leary 1995, Ryan and Deci 2000). According to La Guardia and Patrick (2008), for any relationship to effectively enhance positive functioning and wellbeing it should support all three psychological needs (relatedness, autonomy and competence). They characterise a need-supportive relationship as one that:

> *[A]ctively attempt[s] to understand the person's interests, preferences, and perspectives (autonomy), provide clear, consistent, and reasonable expectations and structure (competence), get involved with, show interest in, direct energy toward the person and convey that the person is significant and cared for noncontigently (relatedness)… In contrast, [to relationships that] are excessively controlling, have unreasonable expectations, are overchallenging or rejecting* (La Guardia and Patrick 2008, p.202).

In this sense, this literature supports the idea that how well people do in any aspect of wellbeing could be directly mediated by the extent others support or undermine these aspects. The implications of relationships on various aspects of wellbeing are, however, seldom explored in SWB studies that principally assess the effect of a

certain measure of social relationships on a global indicator of happiness or life satisfaction. Nonetheless, conducting these studies more systematically could help illuminate the paths through which relationships can influence wellbeing.

Measuring the quality of social relationships as PWB approaches do might be beneficial for programme evaluation as it provides a more detailed view about what people are thinking about when rating a relationship. Nonetheless, only assessing our satisfaction with relationships or even their quality, risks obscuring the negative aspects of social interactions, which can be particularly relevant in contexts of poverty and inequalities in which social programmes occur. Wellbeing studies that explore relationships' negative aspects are rare and instead, there appears to be an overemphasis on the positives, probably as a result of the field's positive outlook (White 2010). Yet, relationships and interactions often involve not only positive but negative aspects such as conflict, rejection, power and control that could have a differential effect on wellbeing (House et al. 1988, Goswami 2011). Similarly, the type of support offered by relationships is not always positive, and can become damaging (Garza 2011, Boutin-Foster 2005, Lincoln et al. 2000).

Recently, some researchers have found that negative relationships are as significant for wellbeing as positive relationships and even have independent effects on it (e.g. Lansford et al. 2005). For example, Goswami (2011) conducted a study on child wellbeing investigating the life satisfaction (SWB) effects of positive and negative relationships independently. In the latter, they included experiences of bullying by other young people, being treated unfairly by adults and negative affect in friendships. The results suggested that negative interactions had a 'disproportionately greater effect' on life satisfaction compared to positive interactions (p.584; also see Finch et al. 1999, Hirsch and Rapkin 1986, Rook 1990, The Good Childhood Report 2014).

These findings indicate that that examining separately positive and negative relationships could enrich our understanding of their implications for wellbeing (Antonucci et al. 1998), although of course many - perhaps most - relationships have aspects of both. This might be even more revealing if we evaluate, as suggested above, their differential role on particular aspects of wellbeing and not just global satisfaction or happiness. However, since this is not widely explored, it is not clear how significant this would be for different aspects of wellbeing or for different types of relationships such as those generated during programme implementation.

A second drawback of PWB approaches that assess the quality of relationships with established indicators is that these can limit the extent to which people can express the significance of relationships in their lives as well as the types of relationships that are important and the reasons why. As shown above, the relationship measures often used by PWB point towards features like attachment, intimacy, closeness or belongingness (Springer and Hauser 2006) that restrict the analysis to close relationships and might be less relevant for more distant or less intimate relationships such as those created in policy contexts[15].

SWB's and PWB's outcome-focused approach to relationships also constitutes important limitations for their use in the policy realm. Firstly, studies on SWB and PWB only capture the final outcomes or impacts of relationships on wellbeing through their quantitative measures, ignoring the complex and fluid processes through which these are produced. Secondly, especially salient in SWB research is a view of relationships as external influences on wellbeing (Ryan and Deci 2001), and wellbeing itself as construed within the individual and by her personality and biological traits.

A good example is Cummins and colleagues' (2009) understanding of social relationships as 'external buffers' of people's life satisfaction. From their perspective, social relationships are external coping mechanisms when the SWB of the person fails to return to its homeostatic equilibrium (the set-point value for a given person)[16]. Relationships thus become an aspect of the environment in which people live that can have a cause-effect association with subjective wellbeing (Gergen 2009). The global questions of happiness and life satisfaction reinforce this view since, as Christopher (1999) defends, these indicators "[cast] the individual as the possessor or owner of his or her own being" (p.143). Indeed, it could be argued that SWB and PWB risk presupposing persons as atomistic and discrete entities that are separate and independent from each other and from society (Gasper 2010); whereas relationships are portrayed as external impacts on a personally created wellbeing (White 2016, Gergen 2009, Atkinson 2013).

This understanding can lead to a duality that is particularly problematic for the policy realm. When the person is seen a self-defining unit that pursues self-chosen goals,

[15] This is shown in Springer and Hauser's (2006) review of PWB surveys in which 9 out of 9 indicators implemented guide the respondent to think about family or friends and to relationship qualities such as support, reciprocity, affection, trust, and warmth.
[16] This is what they call homeostatic defeat, which happens when a person's wellbeing is far off his/her average set-point of adaptation when interacting with his/her context.

her wellbeing becomes a personal property (Christopher 1999) and can only be personally achieved (Sointu 2005) or self-managed (Atkinson 2013). Hence, any failure to achieve wellbeing is attributed to personal failure (Sointu 2005).

Atkinson (2013) rightly problematizes this outlook as it enters the policy realm, suggesting it can lead to policies that "focus primarily on individual deficits in fostering and sustaining positive wellbeing" (p.140). They also run the risk of "de-politicising wellbeing" as the aim becomes "not to change the world but to change the way you feel about it" (White 2010, p.167). Ultimately, taking this position implies losing the complexity of wellbeing and diminishing the role of the social and relational (Gasper 2010). Indeed, as discussed in section 2.5, relationships are barely static, they are constantly in flow, often ambiguous since they can be positive and negative at the same time or in different ways, and their implications for people's lives can also vary in the short and the long term. Although these aspects are difficult to measure, they are still relevant for how wellbeing is experienced by people.

Finally, as this review has shown, the main concern of SWB and PWB research has been close relationships. This reflects the consistent and convincing findings that they have the strongest influence on wellbeing across the globe and the life span, compared to other types of relationships (Argyle 2001, Rojas 2007b, Downie et al. 2008, Land et al. 2001, Michalos et al. 2001). These findings are significant to the policy realm since they have led to several recommendations to governments and organizations to include positive close relationships as goals of their social programmes and development initiatives (e.g. Cummins et al. 2009, Camfield et al. 2009b, Devine 2002).

Today there is an increasing number of programmes which are interested in this. One example is the British association Knowle West Media Centre has developed two programmes that seek to generate spaces for social gathering in localities throughout the country. Also in Britain, the Relationships Foundation has developed many projects since 1993 that seek to promote the quality of marriage (Marriage Foundation), family (Status Initiative, Testing the Test initiative), school (Relational Schools) and community relations (Keep Sunday Special initiative). Although these initiatives are inspired by certain religious values (which are not necessarily

subscribed to by this dissertation), they work both directly with the recipient population and the government to elaborate relationships' focused policies[17].

Although the focus on close relationships like the family is very valuable given the strong evidence about its role on wellbeing, only focusing on them runs the risk of individualising the responsibility of wellbeing in the policy context. Namely, it could appertain the responsibility of achieving wellbeing to the recipient and the relationships within the household, ignoring the role of the social programme in the process. To avoid this, it is argued here, policies and programmes should consider that they themselves reproduce wider structures and generate new social scenarios that can be crucial not only for their own success but also for the subjective wellbeing of their participants.

On the whole, very little wellbeing research has been done focusing on relationships created in institutional contexts, except within health and social care (e.g. Cummins 2005). After an extensive survey of the literature, only a handful of studies exploring quality of interactions between officers and clients and their connection to subjective or psychological wellbeing were found. Most of these studies are directed to caring relationships in nursing homes, hospitals and other health contexts.

The interesting contribution of these studies was identifying that patients valued the interactions with health care providers not only in terms of the quality of the service offered, but also in terms of interpersonal qualities. For example, in a mixed-methods study from the nursing care literature, Merkouris and colleagues (2004) evaluated interpersonal aspects of care such as respect, courtesy, concern from staff, communication with staff and the accommodation of personal preferences. Although the quantitative ratings about the quality of this relationship were around the average scale of 3 out of 5, the qualitative data showed that "nurses' humane behaviour and frank interest in patients' well-being was highly valued by participants" (p.360). This discovery supports the relevance of assessing the quality and meaningfulness of the relationships that happen in institutional contexts and service provision.

In terms of their association with wellbeing, two studies were identified. The first, from a quality of life perspective, Street and Burge (2012) explored staff-resident relationships in elderly homes, finding that positive relationships with staff were

[17] Recently, the UK's Office of National Statistics (ONS) interest on Measuring National Well-being has also prompted monitoring the quality of the country's close relationships and social connections (Randall 2015).

significantly associated with a positive change in the resident´s perceived quality of life after moving to the facilities. Using the SDT framework, Custers and colleagues (2010) examine resident-staff relationships in nursing homes indicating that support for the three psychological needs from staff is essential to reduce depression and increase life satisfaction (see also Custers et al. 2012).

This section presented a brief overview of the overwhelming evidence that SWB and PWB approaches have provided confirming the significance of relationships for how people evaluate their lives. As seen above, these findings are certainly significant for the policy realm. However, they also exhibit several limitations for these studies' practical usefulness in public policy, such as obscuring our understanding of certain types and aspects of relationships that might be necessary if applied to policy contexts. Particularly, it ignores the function of interactions with programme officers. Despite the lack of research within wellbeing, the importance of relationships in public policy has been underscored by a number of development reports and studies. For instance, in the 2004 World Bank Report on *Making services work for the poor*, the agency devoted a whole section on complex relationships between people and service providers during policy implementation and the need to improve their relationship for adequate service provision. The next section expands on the characteristics that distinguish officer-recipient relationships and the social scenario in which they happen through a review of the literature on public policy and development.

## 2.4 Client-agent interactions and the need for a wellbeing lens

As argued in the introduction of this dissertation, struggles for wellbeing happen at all levels of policy-making, from the choice of the normative criteria used to justify programme objectives to the use and satisfaction recipients can derive from the resources and services received. Yet, probably the most direct scenario is that which happens during policy implementation in the interactions between the front-line officers that provide the service or resource and the recipients or participants of the

programme [18] . This section explores some of the key characteristics of this relationship and its significance for wellbeing.

The relationship between officers and recipients was not a primary concern in public policy. This discipline was initially concerned with an earlier piece in the policy process: the design. The assumption was that if you get the design of a programme right this was enough to make sure it was effective. In the 1970s, scholars began to question this, noticing that a significant aspect of programme success was determined at the 'last' stage of the process, the implementation. Indeed, usually in practice there is a dissonance between what is stated in the design and how programmes look on the ground. This implementation gap has often been attributed to how front-line officers execute their work during their interactions with programme participants. A further dimension, which as yet has received too little attention, is officers' unconscious everyday attitudes and practices during interactions with recipients, and how this may run counter to the express aims of the programme.

Front-line officers constitute the most immediate link through which a policy, a social programme or a development initiative achieves its goals. Different kinds of officers are in charge of directly interacting with individuals during the provision of services (e.g. physicians, nurses, counsellors, teachers), resources or information (e.g. bureaucrats, public servants, social workers, development workers, receptionists), as well as during the policing of behaviours - as happens in social programmes like *Oportunidades-Prospera* that are attached to certain conditions[19]. Researchers who have analysed these interactions from the perspective of development studies suggest that these access encounters are inherently political and infused with power primarily as a result of the hierarchical positions officers hold within their institutions. This is exacerbated by the fact that their social identities are often different to those of the recipients, and hierarchical social scripts are played out in their interactions (Wood 1985a, Shaffer 1985, Eyben 2010, Goetz 1997, Lipsky 2010). These two

[18] The literature has used a number of concepts to refer to this relationship, such as *client-agent, officer-beneficiary*, or *client-provider*. In this dissertation, o*fficers* can be called *front-line officers* or more specific kinds like *health staff or physicians*, etc. Programme participants also have been identified in a number of ways, some concepts being more value-laden than others (see Wood 1985 and Goetz 1997 for discussions on this). In contrast to the contested concept of *beneficiary*, this dissertation uses the concepts of *participant* and *recipient* as they do not undermine the agency of the people partaking in a government or development programme.

[19] The characteristics of *Oportunidades-Prospera* are explained in chapter three.

aspects are worth examining to better understand the relational context in which recipients struggle for wellbeing.

During policy implementation, front-line officers are figures of authority. They constitute the client's official gatekeepers to valuable resources, services or information because of the power granted by the institutional architecture of social programmes. In practice, however, this formal power is often intensified as officers can exercise discretion over the way the procedures can be deployed to the final receiver, giving them sufficient sway beyond what is established or can be monitored by the programme. Indeed, the concept of discretion is central to the definition of front-line officers that was first presented by Lipsky in his research on US bureaucracies in the 1970s. Lipsky was the first to coin the term 'street-level bureaucrat' and to thoroughly analyse their functions during implementation. According to this author, front-line officers are "[p]ublic service workers who interact with citizens in the course of their jobs and who have substantial discretion in the execution of their work" (Lispky 2010, p.3).

This need to use discretion can have different causes. Lipsky (2010) pointed out that discretion is a coping mechanism officers use to make programmes operational given the uncertain and complex situation in which they often work. It is not rare that officers work under unclear rules and procedures and face a number of limitations to perform their jobs well. These include insufficient resources, large caseloads, and the non-typical situations that are not outlined in the programme's procedures. Such conditions are especially common in developing countries and in programmes oriented to the provision of services that have the most direct link to wellbeing such as education and health.

In an analysis of service provision for the poor in the developing world, the World Bank (2004) showed that public health clinics are critically understaffed, physicians are required to provide services to disproportionate numbers of patients and with inadequate means such as inappropriate buildings without access to electricity and few resources like medicines and instruments. In remote rural areas it is also common for officers to receive low wages and the incentives for effective service delivery are frail or contradictory, thus absenteeism, mistreatment, corruption and political patronage become widespread practices (see also OECD 2014).

Discretion might not always be negative for reaching policy goals more effectively and for fostering recipients' wellbeing. Of course many front-line officers have the intrinsic

or professional motivation or commitment to provide proper services, and thus they could use their discretion to positively adapt to these uncertain settings. An example would be finding innovative ways of using information to explain to clients the benefits of certain medical treatments such as contraception or pap smear scans.

However, in contexts of high institutional failure, contradictory programme goals, and excessively limited working conditions (as exemplified above), discretion can be more prone to negative uses. Officers can arbitrarily decide how to allocate the resources or services and structure the circumstances in which interactions with participants take place, their frequency, and how much time is spent on each case and the amount and quality of the information provided. For example, if physicians are overburdened with disproportionate programme objectives like achieving large quotas on health treatment applications, they could use their discretion to exert authority over clients' decision-making about undertaking the treatments by making them a condition of access to other benefits. In many contexts officers can arbitrarily choose who deserves the support, what kind of support and how they will provide it (Moncrieffe and Eyben 2007). Hence, although the ultimate effects of front-line officers' discretion vary, officers might find themselves between the conflicting needs of their superiors, their recipients', and their own, which can leave concerns for recipients' wellbeing to last.

Wood (1985a) and Eyben (2006) examine the role of power in this relationship through the concept of labelling (see also Moncrieffe and Eyben 2007)[20]. Although labelling is a common strategy used by lay people in daily decision-making and social interaction, the state and aid organisations tend to use it with the purpose of classifying the recipient population into easily managed categories. This can be of practical use in policy. However, it can also lead to groups being labelled in negative ways that reinforce the prejudices and stigma associated with that label, and this can shape the treatment they receive. For example, labelling recipients as 'beneficiaries' has been disputed for positioning people as passive 'users and choosers' undermining their capacity to be 'makers and shapers' of their own destinies and lives

[20] These studies within the development literature discuss power within and between organisations (e.g. Shutt 2006) but also in the interaction of individuals (e.g. Groves and Hinton 2004, Chambers and Pettit 2004), suggesting that the provision of welfare policy is the result of various levels of interpersonal and institutional interaction and power relations: between the theoretical knowledge within social sciences and policy discourses, between policy discourses and officers, between officers themselves and between front-line officers and clients. This dissertation is focusing on the latter, the last link of this web of power relations, which of course cannot be but influenced by the rest.

(Cornwall and Gaventa 2000, p.50), usually considered a significant aspect of wellbeing. This concept ('beneficiary') also assumes that recipients ultimately benefit from policies and programmes, which of course is not always a given but something that should be submitted to rigorous analysis and evaluation.

These negative labels can also be compounded with the identities participants have in the wider social scenario of policy implementation, producing stereotypes such as the 'lazy poor' or the 'dependent beneficiary'. For instance, in two microcredit programmes directed to poor women in Bangladesh, Goetz (1997) found that front-line officers constantly characterised women as dependent, ignorant, incompetent and timorous. In many unequal societies the apparent reality of these labels is especially reinforced to policy-makers, becoming a tool to justify inappropriate actions or middling accomplishments in their own and the programme's performance. In Goetz's (1997) research, officers' representations of gender and worth conveniently obscured their own responsibility in, for example, informally permitting husbands' control over loans that were originally designed for women and women's productive enterprises. In the context of development aid, Eyben (2010) argues that development practitioners often unconsciously reproduce inequalities and inadequate forms of aid delivery, since they prioritise maintaining a symbolic status within the organisation.

The politics of identity that prevails in the outer social world in which the implementation occurs certainly plays an important role in the way power is exercised during officer-recipient encounters (Eyben and Moncrieffe 2006). Yet, it is in conditions of scarcity and deep social stratification that the distance between the identities of these two actors can be magnified. As Lipsky (2010) recognises, "the poorer people are, the greater the influence street-level bureaucrats tend to have over them" (p.6). In developing countries, the identity asymmetries between officers and recipients in terms of gender, class, race and education tend to be striking. Officers are usually part of (relative) social elites as they are educated, middle class, and frequently male. In contrast, recipients of social programmes usually hold identities that are structurally marginalized in their societies, such as poor, indigenous, illiterate and female. Therefore, some have characterised these interactions as "micropolitical situations that parallel relations in society at large" (Simmons and Elias 1994 citing Waitzkin 1991).

Relationships with participants also become increasingly hierarchical the higher the level of professional knowledge and technical skills required by officers. This is especially problematic in health care contexts where officers suit up as the doctor or clinician with their specialised knowledge able to save lives (Mandlik et al. 2014). These power-heavy forms of engagement can be hidden processes that yet limit the potential for positive interactions and increase their potential counterproductive consequences on the wellbeing of participants.

These hierarchies can exponentially increase as participants hold several negative labels or identities within the social programme and in the outer social world at the same time. Hence, policy-engendered relationships involve interactions between people who are not among either's main reference groups. These social differences facilitate the reproduction of hierarchical relationships and stereotypical conceptions and attitudes towards the other, which according to Wood (1985b) and Shaffer (1985) can destroy identities and recreate them through differentiation.

Particularly relevant for this dissertation is that these hierarchical forms of interaction have the potential of not only affecting people's objective circumstances by restricting access to resources and services for example, but also their thoughts and feelings about their life and themselves (i.e. their subjective wellbeing). Officers have the ability to generate psychological sanctions during their interactions with policy participants (Lipsky 2010). For example, given the disparities in status, officers might dismiss participants when they ask questions, degrade their understanding of the information provided, and have attitudes of hostility and superiority that can undermine the participants' subjective wellbeing.

Similarly, the way in which the actions and attitudes of front-line officers translate the programme's targeting and entitlement procedures to the recipient can also make programme delivery a distressing experience for the recipient. For instance, Salih and Galapatti (2006) argue that "claims that 'it is difficult to know whether people come with complaints to receive counselling support or whether it is to receive the material benefits,' pave the way for clients having to prove they have been violated in order to secure socioeconomic support." (p.133).

Undoubtedly, the possible impacts of this relationship on wellbeing could become more critical the more frequent the interactions with the policy officer are and the more personal is the service provided. For example, it is widely acknowledged that the nature of healthcare services is very personal and could result in lasting (and even

life-threatening!) consequences for the individual's quality of life and wellbeing (Mandlik et al. 2014, Fochsen et al. 2006). Yet, bad relationships in policy contexts do not appear to be isolated events that can disappear with the conclusion of one particularly negative encounter with an officer. These power relations seem to be built into the structure of policy institutions and thus have a cumulative effect on clients. In the words of Lipsky (2010), "[a]t the very least poor people who bounce from one agency to another have reinforced feelings of dependency, powerlessness, and, deriving from these, anger. After sustained exposure to the welfare system, for example, recipients have been found to see themselves as 'undeserving' and 'lucky to get anything at all'" (p.66).

In sum, the way officers implement programmes and their attitudes towards the resources they provide and the participants they interact with can reconstruct participants into objects of the state and reduce the efficacy of programmes as tools for development and wellbeing. Indeed, what is crucial is not only the design of social programmes and development initiatives, but also fundamentally how they are carried out and implemented by programme officers (Galappatti 2003). However, the literature on officer-participant interactions mostly situates its analysis on the effects of this relationship for the success of policies (e.g. Simmons and Elias 1994). When they explore the procedures of implementation it is with the aim of making programmes more efficient and effective (e.g. Williamson and Robinson 2006).

Although the wellbeing outcomes of officer-recipient interactions remain largely unexamined, the notions of power and identity that this literature unveils underscores that this relationship involves important processes of negotiation and meaning creation that might be relevant for our understanding of social relationships and of their implications for wellbeing experiences. A subjective wellbeing approach that solely focuses on outcomes risks obscuring these relational and socio-political processes. In this regard, researchers in the development literature have argued for moving beyond solely an individualised outlook towards a more relational approach that is able to capture policy and programme processes and not only outcomes (e.g. Eyben 2010). This involves recognising the contextual and historical processes that shape the nature of social relationships as well as the dynamic connections between the person and her social relationships. Therefore, looking at officer-recipient relationships demands a more relational approach to wellbeing experiences that cannot be provided by the outcome-oriented perspective of PWB and SWB. This dissertation proposes that a psychosocial approach to wellbeing is necessary as it

gives a stronger weight to the relational aspects of wellbeing. That is, to an understanding of wellbeing as co-constructed in relationships.

## 2.5 Broader outlooks to wellbeing and social relationships: Development and psychosocial approaches

Social relationships take a different form under the light of critical wellbeing research in development studies and psychosocial approaches. From these separate efforts the idea of relational wellbeing is starting to emerge (White 2017), echoing an important challenge to the dominant conceptions of wellbeing examined in previous sections. The common ground between them is a conceptualization of social relationships as intricately linked to how people define and produce wellbeing in daily life. Rather than simply being understood as aspects of the environment that externally impact wellbeing as happens in SWB and PWB, relationships are seen to co-construct wellbeing through various processes like cultural values, identity formation and power struggles. These approaches also take a different epistemological and methodological stance and depart from or have been applied in many cultures outside the global North, stressing the necessity of a contextual analysis of wellbeing. This section presents the conceptual underpinnings behind these proposals at the same time as analysing some of their main findings and their implications for public policy.

The complex association between relationships and wellbeing was succinctly theorised by the WeD[21] research group which engaged into a rich interdisciplinary debate about the meaning of wellbeing, its contextual and social grounding, and its relevance for development and policy. The overall aim of the group was "to develop a conceptual and methodological approach for understanding the social and cultural construction of wellbeing in developing countries" (WeD 2008). This goal is reflected in their three-dimensional approach that conceptualises wellbeing as composed of subjective, material and relational dimensions. Wellbeing, they argue, is what happens between what people have and do not have (material), what they can be and do (relational), and what they feel and think about what they have, and what they

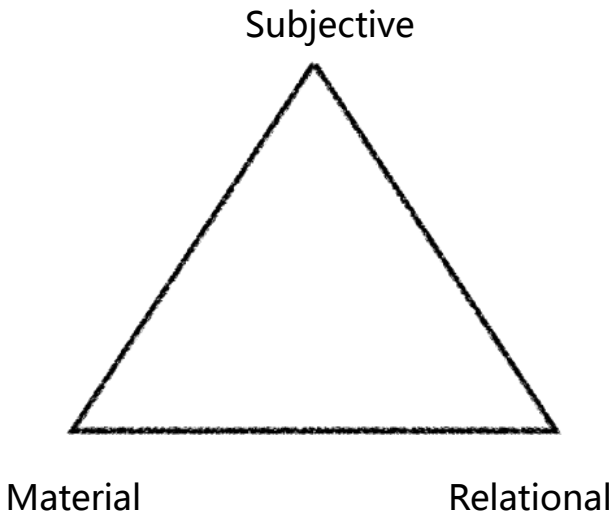
[21] WeD was a research group at the University of Bath funded by the ESRC between 2002 and 2007. Most empirical findings and conceptual analysis were published in the website of the group: http://www.welldev.org.uk. Also refer to McGregor (2007), Gough and McGregor (2007), Camfield et al. (2008), Devine (2008), Devine et al. (2008), White (2008, 2010).

can do and be (subjective) (White 2010) (figure 2.1). The definition of wellbeing offered by WeD mirrors the close and dynamic interaction between the three dimensions:

> *[W]ellbeing is an umbrella concept, embracing at least 'objective wellbeing' and 'subjective wellbeing' (…) [However], both the objective circumstances and perceptions of them are located in society and also in the frames of meaning with which we live. Thus wellbeing is also and necessarily both a relational and a dynamic concept. States of wellbeing/illbeing are continually produced in the interplay within the social, political, economic and cultural processes of human social being. It cannot be conceived just as an outcome, but must be understood also as a process.* (Gough et al. 2007, pp.4-5).

The former quote also offers a number of key ideas about the relational dimension. Particularly about the distinctive way in which the group observes the centrality of relationships in wellbeing through the political, social and cultural practices that ground it and their implications for transforming wellbeing into a dynamic and complex process. Many of these ideas are discussed throughout this section along with findings from other studies that give support to this view. The first aspect to explore, however, is the close interconnection between the relational dimension and the other two.

**Figure 2.1** Dimensions of Wellbeing




Sources: White 2010, Gough and McGregor 2007

For WeD, as for other researchers within this broad approach, wellbeing is conceptualised not just in terms of objective and subjective dimensions, but also as something that is socially and inter-subjectively construed (McGregor 2007). This acknowledgement of relationships is not only conceptual. In much of WeD's empirical research, relationships were found to have a vital role in the subjective and the material reality of people, especially those in contexts of poverty and vulnerability.

For instance, Camfield and colleagues (2009b) conducted a study in Bangladesh that attested that the wellbeing and social relationships of the poor – particularly family and community - are closely interlinked and probably as significant for wellbeing as their material deprivations. Moreover, relationships were not only important as a dimension in themselves, but also connected to the economic and subjective experiences of poverty. In the context of child poverty, a number of qualitative studies support this finding since, through their narratives of their poverty, the children's main concern was found to be not the economic and resource scarcity it entails, but the social and subjective aspects of such deprivations, including social exclusion, embarrassment and shame (Redmond 2008, de Castro 2017).

In adult populations, the relational experiences of wellbeing and poverty are documented by one of the largest and most influential qualitative studies on poverty and quality of life to date. Through the voices of over 40,000 people living in poverty in 50 countries, Narayan and colleagues' (2000) testify that people's narratives of poverty and wellbeing include relational experiences such as powerlessness, voicelessness, dependency, shame and humiliation. These, in turn, are co-constructed in interaction with others in various contexts such as the family, the community and the institutional spheres, affecting people's subjective wellbeing and their ability to access resources. They provide strong accounts of these experiences, for example:

> *When I don't have (any food to bring my family), I borrow, mainly from neighbours and friends. I feel ashamed standing before my children when I have nothing to feed the family (Guinea-Bissau, 1994).*
>
> *When one is poor, she has no say in public and feels inferior. (Uganda, 1998).*
>
> *People everywhere report that they are abused at health clinics and would only continue to go "because we have no choice and need the services." Men, women, and youths state over and over that they are treated like animals,*

*"worse than dogs." They report that even before they could explain their symptoms, they would be shouted at, told they smelled bad, and were lazy and good for-nothing. (Tanzania 1997)*

Indeed, relationships continuously "determine what people are able to do or be, and what they actually achieve or become" (Camfield et al. 2009b, p.88). As a result, a more social or relational approach is taken by increasing numbers of social and humanitarian interventions also called psychosocial programmes. Psychosocial programmes are designed for groups in situations of scarcity, conflict and humanitarian crises. One of their defining features is a concern over the psychological and social dimensions of people's experiences of these events. While acknowledging the importance of the material needs that arise in such contexts, they question the way that these are often the only dimensions of need to capture attention. However, probably the key dispute of these psychosocial approaches was with a-social psychological interventions. Psychosocial interventions, instead, have emphasised the importance of attending not only to the psychological impacts of conflict, but also including social relationships more directly (Salih and Galappatti 2006).

Galappatti (2003) identifies several of these strategies based on the directory compiled by the Psychosocial Working Group (2001) in Sri Lanka. He shows that many are directly addressed to social relationships such as establishing social, cultural, and educational activities, providing community-based social support, mobilising social networks, and strengthening interpersonal skills and people's sense of belongingness (see also Williamson and Robinson 2006). Hence, although psychosocial approaches maintain a focus on the person and her perspectives, they choose to take an integrated approach that includes relationships, social identity and status and culture in the alleviation of ill being in such critical situations (see also Galappatti 2003, Salih and Galappatti 2006, Williamson and Robinson 2006).

Williamson and Robinson (2006) also propose a wellbeing framework for programming particularly in the case of interventions directed at conflict-affected populations. It is composed of seven aspects in which the social and cultural is central[22]. They argue that such an integrated wellbeing approach, that is able to recognise better the various areas that support or undermine wellbeing and their interdependence, would ensure that appropriate programming attention is given to

[22] The seven aspects are: biological, emotional, mental, cultural, spiritual, social and material. However, they underline each context should define the aspects of wellbeing that are more relevant, how to call them or interrelate them.

each of them. Nonetheless, despite the clear interrelationship between dimensions, it is not uncommon that development initiatives primarily concentrate on the material dimension, while mainstream wellbeing approaches (SWB and PWB) largely centre on the subjective dimension. However, not taking into account the relational dimension of wellbeing could obscure the dynamic processes of wellbeing construction and negotiation that occur throughout life and at different contexts and relational spaces. One of such key relational spaces is culture itself.

Numerous research has shown that the meaning of wellbeing varies across cultures and nations (Christopher 1999), as well as the concepts used to describe it (Wierzbicka 2004, 2009). This has been attested by all wellbeing approaches, although it is done with different purposes. Research in cross-cultural psychology has tested wellbeing theories in distinct contexts with the aim of confirming their universal validity and reliability. Although using the simplistic individualistic/collectivistic binary for characterising cultures, most studies have found that emotions and the norms for expressing them vary between societies (Eid and Diener 2001, Markus and Kitayama 1991, Kitayama and Markus 2000)[23].

Conversely, other researchers have argued for a more dynamic understanding of culture. For Miller (2002) cultures not only affect wellbeing at an abstract level as suggested above, instead culture is also "created, sustained and communicated in everyday practices and behavioural routines" (p.100). This understanding of culture is an important ingredient in wellbeing analysis since, as Gough and colleagues (2006) recognise, culture entails "systems of meaning, negotiated through relationships within society, that shape what different people can and cannot do with what they have" (p.25).

In his work with the Raramuris in the North of Mexico, Loera-González (2015) provide evidence for how wellbeing is co-constructed within the larger socio, cultural and historical context in which it occurs. He identifies that the dominant discourse of wellbeing - promoted by the elders - was closely related to ethnic identity. This discourse particularly sought to preserve the cultural and political distinctiveness of

[23] For instance, research has found that in individualistic societies, emotions tend to be self-oriented, internal and private experiences. Yet, in collectivistic cultures emotions are oriented to others and are interpersonal and inter-subjective processes, such as being harmonised with others and being connected to the collective way of well-being (e.g. Uchida et al. 2004, Hitokoto and Uchida 2015). If we take these results from a critical perspective, rather than as supporting a universal take to wellbeing, they make it evident that wellbeing is a situated experience, leading some to argue for a contextual rather than universal approach (White 2010).

this indigenous group, displaying a normative view about what constituted an ideal Raramuri and the everyday behaviour expected from a Raramuri in contrast to 'mestizos'. However, this apparently shared identity was in fact disputed by the younger people who had a different, more integrationist, view of wellbeing.

This case study illustrates how wellbeing discourses and strategies are located and contested in specific historical and political contexts. Thus, wellbeing and the person who is experiencing it should be understood within the socio-economic and cultural contexts in which they occur. Nevertheless, it also suggests that wellbeing strategies and conceptualisations are an important medium of understanding one's identity in contrast to the 'others' (in this case the larger Mexican society captured by the category of 'mestizos').

Indeed, looking at wellbeing as a culturally grounded experience has implications for how subjectivity is understood. For a long time, sociological research has suggested that through the process of socialisation, people create their own identity, motivations, choices, preferences, aspirations and behaviours (e.g. Giddens 1982), all of which are associated with how wellbeing is understood and pursued. Hence, a more sociological approach to wellbeing would argue that the subjective cannot be understood solely as a psychological experience, since culture, values, social norms and social interactions are constantly shaping those inner and subjective evaluations in given contexts.

In their mixed-method study in Bangladesh, Camfield and colleagues (2009a) conclude that relationships had profound influence in "individual´s values, choices, actions and indeed the construction of the self" (p.88). In another study, White (2009) claims that when people are asked about their wellbeing they often find it difficult to talk about their own experience in isolation from others. She argues that "their sense of how things are for them personally is intimately tied up to their sense of how those they identify as 'their own' are doing (this might mean just a single person or could be a very large category)" (p.13). Hence, here subjectivity takes a different form from how is conceptualised by SWB and PWB, since it is not detached from nor externally impacted by the social and cultural context. Rather, it recognises that "people become who and what they are in and through their relatedness to others" (White 2010, p.164).

However, relationships not only shape wellbeing through the lenses people use to interpret life, this literature has also suggested that relationships can determine what

people can do and be at present, and what they can achieve or become in the future. Hence, looking at wellbeing as a relational experience also implies focusing on how it is actively negotiated with others. Calestani (2009) conducted an ethnographic study in El Alto in Bolivia looking at the meaning of wellbeing. Besides pointing to the significance of social relationships, her findings show that in this context closely linked to the Aymara indigenous culture, wellbeing is attributed to the notion of *living well together*. That is, having harmonious relations with others at different levels of social interaction including the household and the community. Calestani reported, however, that harmonious does not necessarily imply that the wellbeing of each individual is always prioritised. Instead, the experience of harmony often entailed individual sacrifice for the group, which was attached to a moral duty to contribute to the group's quality of life[24].

This tension between the wellbeing of the individual and that of others is also related to the ambiguous character of relationships in wellbeing. Research has found that positive aspects of relationships like cooperation and unity coexist with negative aspects like conflict and obligations. Rather than being two opposite poles, positive and negative aspects can occur at the same time within one relationship and are essential aspects of people's ability to live a good life (see Camfield et al. 2009b, Calestani 2009, Huovinen and Blackmore 2015). In their research in Bangladesh, Camfield and colleagues (2009b) documented how "relationships are always malleable, and in the process of negotiating the terms of any relationship people acquire both a sense of identity (often a common identity) and a sense of position within the relationship" (p.82). Hence, social relationships appear to make the achievement and experience of wellbeing a recursive process of negotiation and change as they can constrain or facilitate the strategies people use to be well (White 2015).

This comprehensive role of relationships reinforces an understanding of wellbeing as a process rather than as a state or outcome that has been underscored by a number of researchers within this broad strand (White 2010, 2016, Atkinson 2013, McGregor 2007). In the implementation of a wellbeing approach in policy and development, this reconfiguration of relationships would underline that the promotion of wellbeing should move beyond people's internal traits (e.g. coaching people how to cope with

[24] Her findings also indicate that wellbeing was defined in relational and collective terms through the concepts Suma Jakaña and Suma Qamaña. This society considers the individual and the family unit as the same thing, thus the first term refers to wellbeing at the individual and household level while the second refers to wellbeing at the community level.

the environment) and start to challenge and “transforming the terms on which they engage with others and others engage with them” (White 2009, p.15). This recognition inevitably requires a discussion about power.

Approaches to wellbeing in development also underline the explicit and implicit power in social relationships and in the construction of wellbeing. Research on child wellbeing is particularly sensitive to the power dimension of relationships. Many have found that children’s wellbeing is particularly affected by their hierarchical position in society and the usual power relationships in which they are placed within the household, the school and society in general (e.g. Jones and Sumner 2007, see Crivelo et al. 2009).

Even though it is not surprising that children have such a relational experience of wellbeing, mainstream wellbeing research has failed to recognise that these same relational mechanisms do not fade away in adulthood. As Cohen (2004) argued, our relationships with others “provide the opportunity for conflict, exploitation, stress transmission, misguided attempts to help, and feelings of loss and loneliness” (p.680). People’s wellbeing struggles are thus strongly shaped by the hierarchical terms in which their interactions with others happen, including relationships of dependence, exploitation and unequal power relations (e.g. White 2002, Huovinen and Blackmore 2015). For Camfield and colleagues (2009a), “social relationships constitute a crucial locus of power and identity, and pervade the entire gamut of life activities for all people, irrespective of class, gender or age”. (p.72).

A fundamental premise underlying a notion of relational wellbeing is that all human beings need others to experience and pursue wellbeing. This is more visible when we consider the lives of the most vulnerable such as children, the elderly or the disabled, who may not survive without the help of others. However, all human beings, regardless of their situation, depend on the help or at least from the absence of harm from others (Williamson and Robinson 2006). In many ways, relationships can mediate the resources people can have, how they can access and use them, and the way they feel about their lives and themselves.

These power-heavy mechanisms, however, not only occur throughout the lifetime but also in different relational spaces: within the family (Huovinen and Blackmore 2015), between husbands and wives (Jha and White 2015), between generations (parents and daughters/sons) (Calestani 2009), within the community, the larger society (Loera-González 2015) and with state institutions (PADHI 2009). The interest of this

dissertation lies specifically in the latter arena, which has been primarily explored by psychosocial approaches such as the Psychosocial Assessment for Humanitarian Interventions (PADHI) from the University of Colombo.

PADHI is an initiative that analyses how and what is done in development by accounting for the social, cultural and psychological implications of development programmes. For PADHI, the experience of wellbeing (subjective) cannot be separated from the possibility of achieving it (social), and thus development initiatives need to take into account their function in this process and not just their outcomes. Indeed, psychosocial approaches rightly underscore that even if development initiatives do take a more rounded approach by including psychological and social aspects of wellbeing, the procedures of implementation can often work against these comprehensive objectives through the ethical conflicts and processes of scrutiny conducted by front-line officers (Salih and Galappatti 2006).

In PADHI's research in Sri Lanka they found that wellbeing was a daily struggle mediated by power, discrimination and social connections. In this struggle, they argue, development interventions have a particular role as they can reinforce or challenge the relational systems that determine who benefits or losses from an intervention or programme (see also Abeyasekera 2014). Therefore, this approach proposes a framework based on the principle of social justice which offers a method or tool to social programmes and interventions to assess their impact on people's wellbeing and their processes of implementation (PADHI 2009).

Salih and Galappatti (2006) present a successful example of a poverty reduction strategy in northern Sri Lanka that follows such an approach, particularly taking into account the implementation strategies used by front-line officers. This initiative was directed to resettled women heads of households and integrated a revolving loan fund for income-generating activities with a conventional counselling service and a community social-work approach. As is expected from a psychosocial approach, the initiative responded to the family and community processes that could thwart people's ability to live well in their new communities by designing activities that promoted the recipients' autonomy, identity and the relationships of support needed to cope with the hardships of poverty and resettlement.

This initiative was also explicitly reflective about how the officers engaged with participants during service provision and community meetings, introducing procedures that underlined supportive ways of delivering the interventions from the

design. The initiative intentionally shifted the role of front-line officers from one that monitors and controls, to one interested in how the family was doing overall, their current concerns and the situations of different family members. The authors, however, detected some challenges in the implementation of such an inclusive and horizontal approach to policy delivery. One limitation was the officers' lack of training in the deployment of procedures not through the customary controlling and authoritative role, but through an outlook of mutual support within the group.

They also identified tensions and contrasting expectations between key actors in the project, especially between officers at different levels of implementation. The close relationship between psychosocial workers and recipients permitted identifying pressing needs of recipients that would have not been uncovered with traditional implementation methods. However, officers at higher levels of implementation expressed finding it difficult to harmonise between the traditional demands and objectives of the programme and the requirements of recipients that were voiced through psychosocial workers. In this initiative, the agency's management was very supportive towards the psychosocial workers because their relevance was stipulated in the design. This, however, might not always be the case and thus underscores the imperative for coherence between programme design and implementation.

Despite these implementation challenges, these changes in the processes of programme implementation and the terms of officer-recipient relationships into a more empathic and horizontal interaction resulted in positive wellbeing outcomes for recipients. This initiative was found to contribute "towards, and enhance, [participants'] psychosocial wellbeing by impacting almost directly on their own feelings of competence, their sense of being supported and the development of their skills in problem-solving and management" (Salih and Galappatti 2006, p.139).

This section has discussed the alternative conceptualisations and findings of development and psychosocial approaches that place relationships at the heart of people's daily struggles for wellbeing not only as an environmental factor or an external impact. Their distinct epistemological and methodological outlook permits observing the contested, complex and multifaceted nature of wellbeing. It varies across context and cultures and its meaning and achievement is a process that occurs in the interplay between people and between people and the different relational scenarios in which they act and reside. This outlook has a number of benefits for the entrance of wellbeing in public policy.

Presenting wellbeing not as a state but as a field of struggle reminds us that social programmes that aim at improving wellbeing cannot separate themselves from considerations of social relationships (Taylor 2010). This includes looking beyond the client to the family and community, the larger social processes that help shape people's interactions, and the relationships that are created during the provision of social programmes and aid. Indeed, it is not only crucial to focus on an adequate design of social programmes but also to monitor how the programme itself challenges or reproduces the relational processes that keep people vulnerable.

## 2.6 Conclusion

This chapter has highlighted the ways in which subjective wellbeing is opening up new ways of thinking about public policy. It also recognises that it is as yet unclear how far this will translate into practical action for change. This dissertation aims to contribute to this enterprise by examining the relationships that happen during policy implementation through a subjective wellbeing lens. However, to do so, it was necessary to examine the way in which social relationships are captured by wellbeing approaches and their benefits and limitations for assessing intervention-associated relationships. This was the purpose of this chapter.

Officer-recipient relationships should be increasingly coming under scrutiny as wellbeing enters into the policy realm. The wellbeing literature thus needs to be prepared to explore not only the quality of this relationship, but understand how the larger social structures and dynamics of power and identity permeate into their wellbeing effects. The literature on subjective wellbeing testifies to the major role of social relationships in affecting how people think and feel about their lives. However, as this chapter showed, relationships and their association with wellbeing are not as simple as is sometimes imagined and measured by mainstream wellbeing approaches and thus the usefulness of this literature for the policy realm can be contested. Indeed, SWB and PWB tend to concentrate primarily on the wellbeing impacts of close relationships on global measures of wellbeing. Ignoring the ways in which relationships can contribute or undermine different aspects of subjective evaluations and focusing on relationships qualities like attachment that are relevant only for certain kinds of relationships. They also tend to look at wellbeing as an individualised experience linked to psychological processes, which inevitably places

relationships as features of the environment or external social determinants of wellbeing.

Looking at officer-recipient relationships requires an outlook that permits capturing the social, cultural and power dimensions of social relationships. Indeed, this chapter demonstrated that officer-recipient interactions involve processes of power, negotiation, meaning creation and the reinforcement of forms of social exclusion through identity differentiation, that lie beyond the lens of mainstream wellbeing approaches. If wellbeing aims at guiding and evaluating policy it would need to prove that is capable of shedding light on these broader aspects of policy implementation processes. This chapter argues that development and psychosocial approaches to wellbeing are better equipped for this. They offer a more relational understanding of subjective wellbeing, recognising the dynamic processes through which people co-construct their wellbeing with and through any type of social relationship. For these reasons, this dissertation looks at officer-recipient interactions in the context of *Oportunidades-Prospera* through the lens of development and psychosocial approaches.

# 3. Relationships in public policy: The case of *Oportunidades-Prospera*

## 3.1 Introduction

The purpose of the preceding chapter (two) was making the case for looking at the relationships generated during policy implementation between front-line officers and recipients through a subjective wellbeing lens. This chapter (three) presents and analyses a particular context in which these policy-engendered relationships occur, a national conditional cash transfer programme (CCT) in Mexico, the *Oportunidades-Prospera* programme.

The chapter is structured as follows. First, it presents the Mexican *Oportunidades-Prospera* programme by situating it within the larger context of social protection programmes and the characteristics of conditional cash transfers (CCTs). Next it describes the objectives and main features of the programme, as well as the reasons why it is considered one of the most influential CCTs in the world (section 3.2). This is probably the most evaluated CCT worldwide, thus, section 3.3 describes the results of key evaluations and then focuses on those that are more relevant for the purposes of this dissertation. Section 3.4 defends why this programme is an ideal scenario to explore the role of officer-recipient relationships on subjective wellbeing. It further justifies the focus on the relationship with the health officers in charge of delivering and policing the health conditionalities. Finally, before presenting the conclusions, section 3.5 deconstructs what is currently known about the relationship between health officers and recipients from the empirical studies on the programme's implementation process.

## 3.2 *Oportunidades-Prospera*: A social protection programme in Mexico

The rise of social protection programmes around the world has been a direct response to the Post-Washington Consensus years and the subsequent creation of the MDGs, two episodes that have contributed to placing the poor and the eradication of poverty and hunger as key objectives of social policy. Social protection programmes are characterised by the Organization for Economic Cooperation and Development (OECD) as those "policies and actions which enhance the capacity of poor and vulnerable people to escape from poverty and better manage risks and shocks" (cited in Arnold et al. 2011, p.1). The '3Ps' framework (prevention, protection and promotion) is also an established way of describing the strategies of social protection (Roelen 2011). According to Ulrich and Roelen (2012), this framework

reflects “the potential of social protection to protect people from hardship following poverty, to prevent people from falling into poverty and to promote people out of poverty” (p.6). In practice, these programmes have been primarily focused and evaluated based on poverty reduction, protection and prevention strategies, rather than based on considerations of wellbeing.

Cash transfer programmes can be defined as “direct, regular and predictable non-contributory payments that raise and smooth incomes” (Arnold et al. 2011, p.2). There are different kinds of cash transfer programmes, however. *Conditional* cash transfer programmes (CCTs) specifically, require certain behaviours and actions from the recipient families in order to receive the transfer and over the last few decades they have become an increasingly popular kind of social protection programme, particularly in Latin America (see Adato and Hoddinott 2007 for a brief overview of CCTs).

Mexico is a pioneer in the design and implementation of CCTs, launching the *Oportunidades-Prospera*[25] programme in different guises since 1997. The primary aims of *Oportunidades-Prospera* are to reduce the intergenerational transmission of poverty by combining short- and long-term anti-poverty strategies with a principle of co-responsibility between the state and its citizens. The anti-poverty strategies encompass investment in three basic components that are explained in the next section: education, nutrition and health. Translated into practice, these components entail the programme’s commitment to provide bimonthly cash transfers (short-term) on the condition that families send their children to school, attend preventive health workshops and comply with regular medical check-ups (long-term) (Skoufias et al. 1999, Skoufias and McClafferty 2001, Skoufias 2005).

### 3.2.1 The Education, Health and Nutrition components

The *education component* is directly targeted on children of school age since important portions of the cash transfers are intended to be used as school scholarships for children to stay out of work. The size of scholarships increases with the school grade and are larger for girls than for boys from secondary school onwards (table 3.2). The rise in the size of scholarships is based on evidence that children

[25] The programme is currently named *Prospera*, however, some studies refer to it by its previous names or a combination of them. Since the fieldwork of this dissertation was conducted when the programme was named *Oportunidades* but concluded after its change to *Prospera*, the programme is primarily referred to as *Oportunidades-Prospera*.

have a higher risk of dropping out of school if they are girls and as the school grade increases. The scholarships are also tied to children's attendance record at school. They need to attend to at least 85% of school days each month to receive their scholarship. These scholarships are handed out for the ten months of the school cycle each year. In addition, at the beginning of school year a one-time subsidy is given for school supplies and, to promote high school completion, those who finish their third year of high school also receive a one-time cash transfer. Levy (2006) estimated that 18.7% of all children in Mexico were receiving school grants from *Oportunidades-Prospera* in 2005.

The *nutritional component* is an important objective of this CCT since being nourished is key for being healthy in the short and the long run, while malnutrition is causally associated with a higher risk of infant and child morbidity and mortality and poorer cognitive development and productivity as adults (Hoddinott 2010). Investments in nutrition also make the programme's investments in health and education more effective since being malnourished reduces child cognitive development, school progress, and academic achievement (ibid). This component consists of a basic cash transfer received by all families and an in-kind nutritional supplement provided through the local health clinics, linking this component directly to the health component that is described below. In fact, the receipt of the nutritional benefits is circumscribed to families complying with the health conditionalities. The in-kind nutritional benefit entails a supplement for infants between 4 and 24 months old, malnourished children between three and five years old, and pregnant or lactating mothers.

This dissertation is particularly interested in the health component of *Oportunidades-Prospera* and how it is delivered through front-line officers. In general terms, this component was established under the assumptions that for the poor, being healthy is not only restricted by low incomes but by a low *demand*[26] for preventive health services (Morris 2010). The health component involves two core activities that are in line with the national development plans. First, the attendance of *all*[27] family members

[26] It is interesting that in framing the problem as caused by recipient's attitudes towards health services, any problems in the supply side of the equation can be (at least) minimised.

[27] Most CCTs focus on young children and pregnant and lactating mothers given their original concern of improving human capital and reducing the intergenerational transmission of poverty. Today, this emphasis converges with international policy concerns over child mortality and maternal health. Although *Oportunidades-Prospera* give especial emphasis to children and mothers as well, it has always required all family members enrolled (fathers, mothers, children of all ages and elderly members) to comply with the health check-ups. The frequency of these check-ups varies depending on the circumstances of each member, as explained in section 3.4.

to medical consultations that have the purpose of detecting and preventing common illnesses of the poor in Mexico such as diabetes, tuberculosis, high blood pressure, obesity, diarrhoea and respiratory infections. Second, mothers are required to attend monthly health workshops in the local clinics that provide information about nutritional, reproductive, hygiene and public health topics. Teenage recipients are also required to attend workshops that seek to reduce the incidence of drug addiction and teenage pregnancies. The health component is probably the most rigorously enforced and the most important in procedural terms since the family's stay in the programme is directly associated with their compliance with these activities.

According to Levy (2006) the programme provided a total of 42.5 million medical consultations in 2005. Although this is not an up-to-date figure, it illustrates quite clearly the significant increase in the population serviced by public health institutions as a result of the establishment of *Oportunidades-Prospera*. The programme could not have been able to fulfil this component without relying on the national health system already in place. Therefore, these strategies are delivered through two partner health institutions: the National Health Ministry and the Mexican Social Security Institute (*IMSS-Prospera*).

### 3.2.2 The historical evolution of *Oportunidades-Prospera* in brief

As mentioned earlier, *Oportunidades-Prospera* has had two predecessors (see Levy 2006 and Rocha Menocal 2001 for historical and political perspectives of these transitions). It was originally launched in 1997 as *Progresa* (Spanish acronym for Education, Health and Nutrition programme) under the administration of President Ernesto Zedillo (1994-2000). With this programme came an innovative narrative and design in Mexican social programmes, untying them from the electoral and clientelistic interests that were common in earlier social policy.

It was initially implemented in rural localities with 2,500 or less inhabitants since it was believed that rural poverty was the most extreme in Mexico (Levy 1991). Its initial coverage was 300,000 families in twelve states around the nation, among them Puebla, one of the poorest states in the nation. For the first three years of implementation, the programme incorporated a sophisticated system of evaluation that began with a quasi-experimental scheme to identify the differential impacts of the programme on localities in treatment and control groups (see IFPRI 2002).

In 2002 the programme took the name of *Oportunidades*. Beyond the political causes of this change (the rise of the opposition party in the presidential election of 2000), the goal was enlarging the programme to reach all families living in extreme poverty. Hence, the programme scaled up to all national states, extended its reach in rural areas and incorporated the urban poor (Gardner 2008). By 2005, the programme benefited 5 million families and it had a budget that comprised 0.36% of the national GDP (Levy 2006).

In January 2015, two years after the fieldwork of this dissertation was conducted, the programme was renamed *Prospera* (Spanish acronym for Programme for Social Inclusion). *Prospera* incorporates new aspects such as the promotion of employment and labour inclusion, access to financial services, and extending scholarships from high school to higher education (Sedesol 2016).

Today, *Oportunidades-Prospera* is considered one of the most successful CCTs in the world, praised internationally for its effective design and implementation (Barber and Gertler 2010). As it currently stands, it is the biggest social programme in the history of the country, reaching 6.1 million families - approximately 24 million people - in 2015[28]. This means that in 2010, one out of every four Mexicans was a recipient of the programme. Table 3.1 presents the growth of the recipient population in key years of the programme's evolution at the national level and for the state of Puebla[29].

**Table 3.1** Evolution of the coverage of *Oportunidades-Prospera*

| | National | | | Puebla | | |
|---|---|---|---|---|---|---|
| | **Municipalities** | **Localities** | **Recipient Families** | **Municipalities** | **Localities** | **Recipient Families** |
| 2000 | 2,166 | 53,232 | 2,476,430 | 210 | 3,388 | 205,941 |
| 2005 | 2,435 | 86,091 | 5,000,000 | 217 | 4,358 | 385,118 |
| 2013 | 2,451 | 109,852 | 5,922,246 | 217 | 5,258 | 483,367 |
| 2015 | 2,456 | 115,561 | 6,168,900 | 217 | 5,432 | 491,467 |
| 2016 | 2,456 | 115,275 | 6,073,764 | 217 | 5,378 | 484,516 |

Source: *Oportunidades-Prospera* website, 2016

[28] There are plans to merge *Oportunidades-Prospera* with the Programme of Nutritional Support (*Programa de Apoyo Alimentario, PAL*). This merge is sensible since, in the localities in which this research was conducted, PAL recipients were already complying with the conditionalities of *Oportunidades* but receiving less economic support. This merge would increase the number recipient families to 6.8 million.

[29] All tables present those years in which the programme experienced the most significant changes in its design (2005, 2015). The tables start from the first year available (2000) in the online database of the programme. In addition, the year in which the fieldwork of this dissertation was conducted (2013) is presented and highlighted in grey.

### 3.2.3 Distinctive features of *Oportunidades-Prospera*

It is worth explaining a few basic characteristics of this CCT.

Firstly, probably one of the innovative characteristics of *Oportunidades-Prospera* is its *targeting criterion*, which consists of two levels of selection. At a geographical level, the programme locates those rural and urban communities with a per capita income lower than a certain threshold and whose indicators of marginality such as housing, literacy rates and access to public services are significantly low. The indicators of poverty and marginality employed for this task are those developed by the National Population Council (Conapo) and the Technical Committee for the Measurement of Poverty (CONEVAL). At the earliest stages of the programme only rural localities with 'very high marginality' or 'extreme poverty' were incorporated. Then, progressively all rural and urban localities that fell into any levels of poverty and marginality were integrated. Once the community is selected, the second level of selection happens at the household level. The recipient families are identified through surveys and interviews that assess their socio-economic circumstances including household assets, dwelling conditions and the age, gender and education level of each family member (see Gomez de Leon 1998).

The second key feature of *Oportunidades-Prospera* is the element of *conditionality*. Conditionalities are embedded in the principle of co-responsibility between the state and its citizens. This entails that the government commits to provide cash transfers if recipients actively participate and contribute to alleviate their own poverty. Following Levy (2006), considered the architect of the programme, there are several rationales for imposing conditions to the transfers. On the one hand, it is believed that imposing conditions raises the impact of cash transfers if they are linked to 'socially desirable behaviours'. Of course the meaning of 'socially desirable behaviours' can vary between contexts. Although in Mexico, as in most CCTs, these have been defined as attending school and using health service given the low levels of schooling and the incidence of specific health problems.

On the other hand, the concept of conditionality also serves the political purpose of validating the existence of the programme to the eyes of the larger population. A recent study found that 74% of Mexicans think that the main causes of poverty are the 'personal characteristics of the poor' such as lack of education and substance abuse. However, 30% of these Mexicans (the largest proportion) specifically relate it to 'laziness' (CEEY 2013). Hence, the emphasis on conditionalities could increase the legitimacy of the programme and reduce the public's perception of it as a hand

out or a gift to the 'underserving' poor. Yet, it could also promote and amplify the misconceptions of the poor that maintain them as socially excluded, vulnerable, discriminated and ultimately poor.

Indeed, the conditionalities of CCTs like the *Oportunidades-Prospera* programme are not without its critics some of which can be related to a wider notion of wellbeing. For example, Martinez (2011) argued that while the conditionalities seek to promote the capabilities of participants in terms of education, health and nutrition, they also limit their freedom and agency to choose what kind of interventions (particularly in terms of health) are appropriate and desirable for them. For instance, in practice, the programme can require female participants to undergo pap smears or use contraceptives without providing a proper explanation of their benefits and without consideration of their values or perspectives. This way of implementing conditionalities could inhibit the transformation of recipients from passive receptors of benefits to empowered agents of their own progress, as the programme claims to deliver.

The *determinants of the size and kind of benefits offered* by *Oportunidades-Prospera* are its third distinctive characteristic. In addition to the families complying with the conditions, the size of the cash transfer and type of benefits received in the three components depend on the household composition, including age, gender and household size. Yet, over the years, the benefits delivered have been gradually modified and many changes have been a consequence of the programme's response to the evaluations it has undertaken (Levy 2006). Table 3.2 presents the evolution of the benefits.

The top of the table shows the direct cash transfers provided to all families based on household composition. The nutrition and food transfers are delivered to all families, these summed to a minimum of $445 pesos each month in 2013[30] (the year this research was conducted). Those families with infants or elderly (70 years and older) members receive extra cash transfers.

The middle section of the table presents the school grants - the education component - which increase with each school year and for girls (from secondary school). At the early stages of the programme, the scholarships ran from 3rd grade of primary school

[30] To give context to this figure, in 2013 the minimum wage was 61.38 pesos a day, that is, approximately 1,227.6 pesos a month.

to the last year of secondary school. This was gradually expanded to high school (2005) and higher education (2015).

**Table 3.2** Monthly cash transfers of *Oportunidades-Prospera* (Mexican Pesos)

| Direct Cash Transfer | 1998 | 2006 | 2010 | 2013 | 2015 | 2016 |
|---|---|---|---|---|---|---|
| **Nutrition Transfer** | 95 | 180 | 215 | 315 | 335 | 335 |
| **Food Transfer** | - | - | 120 | 130 | 140 | 140 |
| **Elderly Transfer** | - | 250 | 305 | 345 | 370 | 370 |
| **Infant Transfer** | - | - | 100 | 115 | 120 | 120 |
| **Education Grants** | | | | | | |
| **Primary school** | | | | | | |
| First | - | - | - | 165 | 175 | 175 |
| Second | - | - | - | 165 | 175 | 175 |
| Third | 65 | 120 | 145 | 165 | 175 | 175 |
| Fourth | 75 | 140 | 170 | 195 | 205 | 205 |
| Fifth | 95 | 180 | 215 | 250 | 265 | 265 |
| Sixth | 130 | 240 | 290 | 330 | 350 | 350 |
| **Secondary School** | | | | | | |
| **First** | | | | | | |
| Men | 185 | 350 | 420 | 480 | 515 | 515 |
| Women | 195 | 370 | 445 | 510 | 540 | 540 |
| **Second** | | | | | | |
| Men | 195 | 370 | 445 | 510 | 540 | 540 |
| Women | 220 | 410 | 495 | 565 | 600 | 600 |
| **Third** | | | | | | |
| Men | 205 | 390 | 470 | 535 | 570 | 570 |
| Women | 240 | 450 | 540 | 620 | 660 | 660 |
| **High School** | | | | | | |
| **First** | | | | | | |
| Men | - | 585 | 710 | 810 | 865 | 865 |
| Women | - | 675 | 815 | 930 | 990 | 990 |
| **Second** | | | | | | |
| Men | - | 630 | 765 | 870 | 925 | 925 |
| Women | - | 715 | 870 | 995 | 1,055 | 1,055 |
| **Third** | | | | | | |
| Men | - | 665 | 810 | 925 | 980 | 980 |
| Women | - | 760 | 920 | 1,055 | 1,120 | 1,120 |
| **Maximum amount of transfer** | | | | | | |
| Family with children in primary and secondary school | 585 | 1,095 | 1,505 | 1,530 | 1,350 | 1,350 |
| Family with children in primary, secondary and high school | - | 1,855 | 2,425 | 2,550 | 2,470 | 2,470 |

Source: Adapted from historical data about the size and kinds of cash transfers (https://www.prospera.gob.mx/swb/es/PROSPERA2015/Monto_de_los_apoyos)

Finally, the cash transfers also have established maximum amounts that any family can obtain. These are presented at the bottom of table 3.2. According to Levy (2006) the rationale for placing ceilings on the size of the transfers is to discourage families from continuing having children to obtain a greater economic support from the

programme. This assumption is problematic to say the least, as it directly contradicts the programme's discourse of empowerment and reifies long-held negative stereotypes of the poor that could permeate in their interactions with front-line officers implementing the programme's conditionalities.

The fourth and final characteristic of the programme is its intention to specifically *advance the interests of girls' schooling and women's health*, prioritising these over those of men and boys. This emphasis on girls' education is based on evidence that poor parents often must give priority to the education of some of their children, a decision that tends to favour boys over girls. *Female heads of households – mostly mothers* – are also given a special role in the programme by making them the principal connection between the programme and the participant families. Paradoxically, the way in which the programme achieves this is through reinforcing conventional gendered stereotypes of women and their roles within the home.

In this sense, the cash transfers are directly delivered to mothers based on two assumptions. The first assumption is that women perform the traditional role of the housewife within the family. Thus, they have the time and the possibilities to comply with the activities of the programme. The second assumption is based on an accumulation of research showing that the objectives of the programme have a greater likelihood of being accomplished because of the nature of motherhood. That is, women are more likely to use the resources provided by the programme for the good of their children and the family as a whole (see Behrman 2007). As a result, women are the principal responsible actor of the fulfilment of their own and their family's co-responsibilities. However, as Maxine Molyneux (2006) argues, this strategy potentially can increase the responsibilities of women both within and outside the household (see also Adato and Roopnaraine 2010a).

The programme activities to which female recipients are accountable for are not few. These are related to the two primary roles that female recipients can take in the programme. The first is adopted by all recipients and entails them being responsible for receiving the benefits and managing them at home. The activities they have to invest time in to fulfil with this responsibility include traveling to the centre of their municipality to collect their transfers, attending to meetings at school with teachers, routine meetings organised by *vocales* (see below), regular visits to the health clinics for their own and their children's medical appointments, and attending the health workshops.

The second role taken is that of *vocales*[31]. *Vocales* are female recipients elected by their peers to be part of the Committee of Community Promotion (*Comité de Promoción Comunitaria*). There are four kinds of positions they can take: 'education', 'health', 'nutrition' and 'control and surveillance'. No matter the position they take, the functions of *vocales* are to be the liaison between the recipients and the programme officials, they provide information to recipients about the components of the programme they represent, make sure recipients comply with the conditionalities and organise most activities of the programme[32]. Hence, *vocales* undertake additional activities on top of the usual deeds as recipients described above. For example, although this could vary across locality, *vocales* receive additional workshops about the procedures of the programme, about the requirements of their role, and about how to manage groups of people and other personal, social and psychological skills.

It is important to note that *vocales* do not receive any material or economic benefits from the programme for conducting this role, it is voluntary. From its inception, the programme has characterised by successfully eliminating the clientelistic practices that were common in former anti-poverty programmes. *Vocales* do benefit, however, from the knowledge they obtain through the training they receive as part of this role.

## 3.3 Evaluations of Oportunidades-Prospera

The international praise of *Oportunidades-Prospera* partly comes from its continual internal and external evaluations and the government's responsiveness to the resulting recommendations. In fact, probably the largest and most rigorous evaluations of social protection programmes in general have been based on this Mexican CCT (e.g. Adato and Hoddinott 2010, Fiszbein and Schady 2009). Hence, the literature that reports the outcomes of the programme from its inception is exceptionally large and thus this dissertation does not attempt to conduct a comprehensive review. Instead, this section first presents some of the major quantitative and qualitative evaluations and then concentrates on those findings that are more relevant for the purposes of this dissertation, particularly those using a wellbeing lens and focusing on social relationships.

[31] *Vocales* is the plural of the term *vocal*, which in Spanish relates to a position in an organisational structure that means 'spokesperson'. Both terms are used throughout this dissertation when referring to this group of recipients.
[32] The number of *vocales* selected depends on the number of recipient families within each locality. The official length of the position is 3 years.

### 3.3.1 Quantitative Evaluations

Skoufias (2005), IFPRI (2002) and Adato and Hoddinott (2010) review the short-run and estimated long-run impacts of the programme through the original data set of the experimental evaluation conducted between 1997 and 2000 (then *Progresa*). These quantitative evaluations have largely confirmed the success of the programme in increasing household income and consumption, raising school attendance, and improving health and nutrition (IFPRI, 2002, Campos 2012), although they do not say much about broader impacts on the wellbeing of recipients. A brief review of the findings in each component of the programme is presented next.

In terms of education, these studies find that the programme has increased children's school attendance, especially that of girls and at secondary school. If these effects are sustained over these children's school age, some studies predicted that on average they will have an increase in years of education, from 0.5 to 0.9 years (Behrman and Parker 2010) and 8% more income (Skoufias 2005). Schultz (2000) also found that *Progresa* increased enrolment rates by 1.45% for girls and 1.07% for boys at primary school level, but up to 9.3% for girls and 5.8% for boys at secondary school level. *Progresa* also promoted school entrance at early ages, better grade advancement and less grade repetition (Behrman et al. 2000). In the short-run, children receiving the scholarships showed lower drop-out rates and higher re-entry levels.

Despite these positive (though small) results in terms of school attendance, the short-run evaluations suggest that there are no significant effects on school performance (Skoufias and Parker 2001); while long-run studies (Behrman et al. 2010) find positive but limited increases in test performance. However, Behrman et al. (2005) found that the outcomes of increased schooling offered by *Oportunidades-Prospera* are mediated by the quality of schooling available. Specifically, their results suggest that longer exposure to school as a result of the programme has no impact on achievement test scores. These results show that while the programme addresses issues of access to schooling, it does not attend to the important theme of the quality of the education received by recipients.

In terms of health and nutrition, the central components for this dissertation, Skoufias' (2005) compilation claimed that the incidence of disease was reduced by 12% for children and 19% for adults measured by the number of days they report in ill or incapacitated (also Gertler 2000). Similarly, children between 12 and 36 months of age showed a reduction in their levels of stunting by 10% and a greater level of caloric

intake as a result of the nutrition cash transfer of the programme (see Hoddinott 2010, Hoddinott and Wiesmann 2010, Behrman and Hoddinott 2001). This suggests that families are indeed using the cash transfer for its intended purpose. As seems natural in a conditional programme, Gertler and Boyce (2001) revealed that visits to health clinics increased 18.2% after the first year of implementation. These were particularly high for pregnant women's attendance to health consultations during their first trimester of pregnancy. There is no data about the effects on maternal mortality (Morris 2010).

At the early stages of the programme, the evaluations found some initial problems in the provision of the health component. For instance, Adato et al. (2000a) found that recipients felt uncomfortable receiving talks about pap smears and contraceptives from male doctors. They also found problems in the formula, provision and use of the nutritional supplements which reduced their effectiveness. Rivera et al. (2004) found that because of this issue, the programme reduced the levels of anaemia in children by only 10.6% while the incidence of anaemia remained high in the treatment localities (44%). This finding led to modifying the formula of the nutritional supplements to improve the absorption of iron, in 2005. More of the limitations in the health component are discussed in section 3.5.

This CCT constitutes one of the most comprehensive policy actions that exist today by combining a number of strategies to reduce poverty (income, health, education and nutrition). Yet, the former review of key evaluations show that they have paid little attention to a more holistic understanding of people's wellbeing experiences in their interface with this social programme. Indeed, it is noticeable that objective indicators that measure the most direct effects of this programme dominate in these studies. In an analysis of 221 evaluations of CCTs like *Oportunidades-Prospera*, Hagen-Zanker and colleagues (2011) found that the main indicators usually considered are education (27%), health (22%), and employment (13%); while the least included are food security (6%), inequality (4.5%), and food expenditure (1.8%) (personal calculations).

Although these indicators constitute a useful tool since they involve logical areas of impact of the programme, they are limited in at least three ways. Firstly, when the programme evaluated is conditional, an important question to ask is whether some of these measures such as attendance to school or the health centres are capturing the success of the programme in raising health and human capital, or whether they are simply reflecting the capacity and motivation of recipients to meet the conditions.

Secondly, as suggested in the previous chapter, objective indicators leave important knowledge gaps as they also provide very little information about what people can actually achieve with these 'successes' and exclude people's perceptions and experiences of the programme and of its effects on broader conceptions of wellbeing. Finally, at most these objective indicators can observe certain programme outcomes while neglecting programme processes at the level of implementation through front-line officers, the main interest of this dissertation. As seen in chapter two, the relational processes that occur during programme delivery and in the interface between officers and recipients, might have as great an effect on people's wellbeing as the intended outcomes.

### 3.3.2 Qualitative Evaluations: Focus on Relationships

In contrast to the quantitative evaluations of *Oportunidades-Prospera*, a number of qualitative evaluations have been conducted uncovering quite a distinctive view of the programme, especially in terms of unintended implications for the social relationships of recipient families and communities (see Molyneux 2006, Escobar Latapí and González de la Rocha 2004, Rubio 2002, Adato 2000, Adato et al. 2000b, Macauslan and Reimenschneider 2011 for the case of Malawi and Zimbabwe).

In terms of the interactions that occur within the family, Molyneux (2006) argues from a gender perspective that the bias in the programme's strategy intended to improve women's position inside the household, was not necessarily translated into positive outcomes in their empowerment (see also Escobar Latapí and González de la Rocha 2004). Although both positive and negative effects on the quality of husband-wife relationships have been found (see e.g. Adato and Hoddinott 2010), Molyneux (2006) identified that the competition for the control of the cash transfers increased the incidence of domestic violence. Another unintended consequence of the programme's procedures seems to be an increase in the economic demands on women in addition to domestic ones since studies suggest some men choose to contribute less economically to the family (see also Rubio 2000).

On the other hand, although there is evidence that the relationships between recipients have been strengthened as a result of their entrance to the *Oportunidades-Prospera* programme (Adato 2000), there are indications that the programme has negatively transformed community relationships as a result of its targeting procedure and selection process (see also Escobar Latapí and González de la Rocha 2004). A

new label that differentiates people within communities was introduced: who is a recipient and who isn't? As Adato (2000) noted, this social division created feelings of resentment and envy, as well as the proliferation of gossip between these groups. Some people did not understand why their neighbour was chosen to be recipient and they were not if both share the same poverty and living conditions. Adato (2000) additionally observed that these feelings had consequences for the customary ways of interaction in the community. In the sample of this qualitative study, for instance, non-recipients decided to retreat from the traditional communal deeds because of the belief that the recipients of *Oportunidades* should participate more because they were obtaining government benefits.

These indirect effects of the programme on social relationships are intrinsically important for subjective wellbeing since, as shown in the previous chapter, having positive relationships between neighbours and within the family is a central aspect of living well from people's perspectives. However, besides not considering those relational processes that happen within the grounds of the programme, (between front-line officers and recipients), these studies do not examine the possible negative consequences of these changes in recipient's close relationships on different aspects of wellbeing, such as self-worth, social status, and economic support from neighbours. This is an empirical question that is left unanswered by these evaluations but that a wellbeing approach could help elucidate.

### 3.3.3 Evaluations from a wellbeing perspective

There is a small but emerging literature that evaluates CTs like *Oportunidades-Prospera* through a wellbeing lens. From a quantitative perspective, Handa et al. (2014a) incorporated SWB indicators in a large-scale survey evaluating the Kenyan (unconditional) cash transfer programme for Orphans and Vulnerable Children (CT-OVC). In terms of methods, their analysis confirms that subjective indicators of wellbeing can be applied in large-scale surveys and in a sample composed of rural participants in a developing country. More substantively, however, the study finds significant, strong and positive effects of the cash transfer on present and future SWB. Specifically, recipients receiving the cash transfer were more likely to feel happy and to feel positive about their future than non-recipients.

In another study, Handa and colleagues (2014b) demonstrate that the CT-OVC benefits contribute to the subjective wellbeing of parents, which in turn have a positive

effect on the psychological wellbeing of their adolescent children through the development of a more positive family environment. In relation to psychological health, Kilburn and colleagues (2016) find that the same cash transfer reduces the probability of depressive symptoms by 24% among male adolescents receiving the transfers. In the context of *Oportunidades-Prospera*, the only study found to explore the wellbeing of recipients was published by Palomar-Lever and Victorio-Estrada in 2014 using PWB and SWB approaches. However, the article only describes the wellbeing determinants of adolescent recipients and does not explore any role of the programme on these wellbeing outcomes.

These quantitative studies provide justification for the application of subjective wellbeing indicators in the analysis of CTs that is valuable in its own right. Yet, as it was discussed in chapter two, it is possible to argue that they still employ a narrow set of indicators that are not able to explain the reasons behind these positive results beyond what is measured, including the processes through which these outcomes were achieved. In contrast to quantitative studies taking SWB and PWB approaches, a very recent series of articles published by researchers from the Overseas Development Institute (ODI) presents two (mainly) qualitative studies that take a psychosocial wellbeing approach to assess cash transfers in the Middle East and Africa.

Samuels and Stavropoulou (2016) propose using the psychosocial model of Inner Wellbeing (IWB) [33] (White et al. 2014) to analyse the qualitative findings of (unconditional) cash transfers in the Middle East and Sub-Saharan Africa. They use the IWB approach to explore the differential role of the programmes on each of the seven domains of IWB[34], a disaggregated analysis that is not possible to conduct with the global indicators of SWB. Their findings attest that receiving the cash transfer had positive effects on people's sense of economic confidence (by increasing financial security), their sense of agency (by increasing their feelings of control over their lives and reducing their dependence on others), their mental health (since increased financial security reduced feelings of stress and anxiety) and their sense of competence and self-worth. The programme also improved intra-household relationships between spouses and between parents and children (by increasing collaboration among family members and reducing tension and violence) and

[33] The same model is used by this dissertation and is explained in chapter four.
[34] The domains are economic confidence, agency and participation, close relationships, social connections, competence and self-worth, values and meaning, and physical and mental health.

improved their social connections (by integrating people and reducing levels of discrimination and shame).

Samuels and Stavropoulou's data also showed that the cash transfer had adverse effects on inner wellbeing through several channels. For instance, mirroring the results of Molyneux (2006)'s qualitative study on *Oportunidades*, this study also identified that in some cases people's close relations and social connections were negatively affected since the cash generated tensions and conflicts for its control within the family and increased feelings of envy between neighbours and extended family members. The authors also found adverse effects on the recipients' competence and self-worth arising from two relational processes, first from the social stigma of becoming a recipient, and second from the mistreatment received from programme implementers during their interactions. This study, thus, provide a more comprehensive view of the relational processes and the channels through which participating in a social programme like *Oportunidades-Prospera* can affect subjective wellbeing.

On the other hand, Attah and colleagues (2016) provide evidence of the roles of cash transfers on psychosocial wellbeing from two studies, a cross-country qualitative research from Ghana, Zimbabwe and Lesotho and a mixed-method evaluation of a cash transfer in Kenya. Both studies reinforce previous findings about the association between the material benefits that the cash transfer provide and the subjective and relational wellbeing of recipients:

> *"[T]here's a self-reinforcing cycle that leads from increased material wellbeing towards increased self-esteem (for example, ability to be clean and wear good clothes, ability to pay into risk-sharing arrangements, and so on), which then has effects on social integration and interactions (for example, diminished stigma from teachers, increased respect gained from other community members, and so on), which in turn can positively affect other relevant development outcomes (for example, improved performance in school, increased support from the community at a time of need, and so on)."* (pp.1125-1226)

The conclusions of the aforementioned articles (Attah et al. 2016 and Samuels and Stavropoulou 2016) highlight the added contribution of a relational approach to wellbeing for assessing CTs. According to Attah et al. (2016), their results reveal the difficulty of separating subjective aspects from relational aspects of wellbeing since often the accounts of recipients coupled their inner feelings (of purpose in life, self-

esteem and autonomy) with the social and relational contexts in which they experienced them (such as being respected and accepted by their neighbours, classmates or programme implementers, obtaining social status and being able to engage in different social scenarios and institutions). Both studies also briefly mentioned a possible role of front-line officers like programme implementers (Samuels and Stavropoulou 2016) and school teachers (Attah et al. 2016) on the wellbeing of recipients, even though their purpose was not to explore these relationships in depth. Furthermore, Samuels and Stavropoulou (2016) concluded that a psychosocial approach to wellbeing like IWB is substantially useful to evaluate CTs and to design programmes that provide a more holistic psychosocial support to recipients.

### 3.3.4 Final considerations

The purpose of this dissertation is to identify and assess the association between subjective wellbeing and the relational processes that happen within the delivery of the *Oportunidades-Prospera* programme that cannot be captured with the standard evaluation methods used (see Devereux et al. 2013 for a similar proposal). This section exposed that most evaluations of *Oportunidades-Prospera* focus on objective outcomes such as school attendance and health improvements. There is however no knowledge about the possible wellbeing effects of the *Oportunidades-Prospera* programme, although research elsewhere begins to underscore the appeal of a psychosocial wellbeing approach to assess programme outcomes and processes.

In addition, similar to the gaps found in the wellbeing literature presented in chapter two, the available qualitative evaluations of the *Oportunidades-Prospera* programme that discuss the social processes that occur around the programme concentrate primarily on household and community interactions. However, although promoting access to health and education, and improving family and community relationships are fundamental steps towards tackling poverty and improving the wellbeing of poor recipients, this outlook disregards other social factors behind poverty and illbeing such as power relations, discrimination and social exclusion. These can contribute to keeping people in poverty despite personal motivation to overcome it or having access to human capital and health services.

This dissertation proposes exploring the extent to which *Oportunidades-Prospera* reinforces or challenges these relational constraints to wellbeing during the provision

of welfare. Specifically, it intends to analyse how programme processes and delivery mechanisms through front-line officers affect programme outcomes and (more importantly) can be wellbeing enhancing or diminishing for participants. The next sections (3.4 and 3.5) seek to make the case for this emphasis on officer-recipient relationships in the implementation of the health conditionality of *Oportunidades-Prospera* by exploring the characteristics of the implementation procedures and evidence from previous empirical evaluations of the programme.

## 3.4 The provision of the health component of *Oportunidades-Prospera*: officer-recipient relationships

Conditional cash transfer programmes like *Oportunidades-Prospera* are ideal scenarios to explore the relationship between front-line officers and programme participants. As was mentioned, they seek to transform people's lives in the domains of education, health, nutrition and income. The mechanisms through which these objectives are pursued, however, place recipient families in new relational scenarios where they hold long-term interactions with front-line officials at different stages such as targeting, payment, delivery of services, and monitoring. The element of conditionality generates even more constant relationships than other social programmes since families' behaviours and actions are continuously supervised by different kinds of officers like teachers and health staff. The high importance of officer-participant interactions in the delivery of this programme justifies Macauslan and Reimenschneider's (2011) proposition for "reconceptualising cash transfers as ongoing processes of intervention in a complex system of social relations" (p.60). Probably the most complex and significant interaction generated within the provision of this programme is that between recipients and the health staff.

As mentioned in section 3.2.1, given the amount of material, human and organisational resources needed to deliver the health component of the programme, *Oportunidades-Prospera* partnered with the two largest health institutions in Mexico, the National Health Ministry (Secretaría de Salud) and the National Social Security Institute (Instituto Mexicano del Seguro Social, *IMSS-Prospera*). The health officers – doctors, nurses, dentists and interns – in *Oportunidades-Prospera* are primarily accountable to one of these institutions and thus formally are not direct employees of the programme. Nonetheless, they have the crucial functions of delivering and

supervising the health activities that the families (primarily mothers) need to comply with as a result of their involvement in the programme.

The health staff directly monitors the two core activities stipulated in the official regulations of *Oportunidades-Prospera* that were introduced in section 3.2.1. To recapitulate, the first official condition is attending regular family medical check-ups[35] scheduled twice a year with the requisite that all members enrolled in the programme attend (usually at the same day/time). Conversely, those who are pregnant or lactating, and those who suffer from certain ailments are required to be monitored by medical staff once every two months. Health workshops, the second official conditionality, involve monthly talks about illnesses and preventive health measures delivered by the medical staff and directed to mothers. They usually last an hour, cover topics such as sanitation, illness detection, hygiene, family planning and nutrition (Adato 2000), and are scheduled by the health staff based on their own activities within the clinic.

The health staff strictly and constantly monitor people's compliance with these conditions through an attendance record retained at the clinic ('S1 form') and an appointment booklet that the family representative keeps ('*carnet'* or '*cartilla familiar*'). This booklet contains the scheduled appointments for each family member during the entire calendar year (Adato et al. 2000a). In practice, each turnout from the recipient is signed by a health officer and then submitted to the *Oportunidades-Prospera's* system electronically. Failure to comply with one appointment entails an economic penalization in the next cash transfer, but failing to comply for four consecutive or six non-consecutive months causes the permanent expulsion form the programme (Adato 2000). Therefore, for recipients their attendance to the health activities and the signature of the health officer in their attendance record are critical.

In addition to these two official conditionalities, there seem to be a few unofficial requirements in place that implicate participants in unpaid jobs under the supervision of health officers. These can include different kinds of tasks such as cleaning and maintenance work at the clinic and in public places, as well as participating in campaigns promoting health treatments or sanitation activities. The recipients involved in these activities are rotated at varying rates, some activities are conducted by all recipients but others by a specific group identified in some places as *members of the health committees*. A number of studies and evaluations of the programme

[35] These usually entail taking record of each patient's weight, body-mass index, and a brief consultation with the doctor.

have documented them (Adato 2000, Adato et al. 2000a, Agudo Sanchiz 2012, and Smith-Oka 2013). However, the programme does not appear to regulate these activities, suggesting these are informal practices behind the implementation procedures of *Oportunidades-Prospera*.

In an external evaluation of *Oportunidades-Prospera* (then *Progresa*) conducted by the International Food Policy Research Institute (IFPRI), Adato (2000) examines these activities - or what she calls *faenas. Faenas* are identified as *volunteer* activities that are not part of the programme but that were informally associated with it in most localities. Adato (2000) tracks down their origins to the communal work traditionally conducted before the establishment of the programme[36]. In the two sites where this dissertation developed, *faenas* are still described by officers and recipients alike as 'volunteer' activities, although in practice recipients have little say in their degree of involvement in them (see also Agudo Sanchiz 2012). They have become informal requirements since physicians consider *faenas* to produce important environmental, hygiene and health benefits for the localities (Adato et al. 2000a). Arguably, however, tasks such as cleaning the clinic, doing plumbing work, fixing the cistern or paying for it to get fixed should be fulfilled by the municipal government or the national health institution and not by the recipients of the programme.

The lack of information and their informality make it difficult to determine the frequency of these practices, the level of participant involvement and the types of tasks entailed. It is also difficult to reach any conclusion as to why they are allowed or practised, and what are the incentives behind them. An administrative 'explanation' is that *faenas* have been a useful tool for the national health office to achieve aims such as keeping certain levels of sanitation in the clinics without hiring cleaning staff, reducing the workloads of current health officers, or meeting other targets such as promoting medical procedures to reach larger policy quotas (e.g. vaccinations and use of contraceptives).

An important discussion that arises from the existence of *faenas or health committees* is their consequences on the relationships between officers and recipients. Indeed, for this dissertation, the most important characteristic of these activities is that they are designed and regulated by the health officers in each clinic, and used as part of

[36] As mentioned in section 3.3.3, there is evidence that *faenas* have generated tensions between recipients and non-recipients, creating new social divisions within the localities and transforming community activities into social programme tools (Adato 2000). Research also suggests that participant women are usually those involved in the *faenas* as it is easier for officers to convince them to participate than to convince their male counterparts (Adato 2000, Adato et al. 2000a, IFPRI 2000).

the requirements families must comply with to receive their benefits. These activities and their management through health officers could potentially transform the officer-recipient relationship from one between clients and agents of the state - or between patients and doctors more particularly – to a relationship between superiors and subordinates. This transformation thus inevitably involves a new set of hierarchies in an equation that – as argued in chapter two – is already charged with issues of power, authority and forms of control that are potentially problematic for wellbeing. For instance, unregulated *faenas* can increase the ability of health officers to execute their discretionary power over the programme's procedures and over the participant's activities within and outside of the programme.

In addition to these power-laden features of the officer-recipient relationship generated by *Oportunidades-Prospera's* processes of implementation, the frequency of interactions is rather high for a social programme. Levy (2006) estimated that recipient families meet the health officers an average of 7.8 times every year for medical consultations, which in addition to the monthly workshops, they sum up to 20 days of formal interactions with officers. These figures, however, do not consider non-compulsory medical visits to the clinic (when people are ill) and the health campaigns organised and monitored by officers. They also do not include the interactions that *health committee members* and *vocales* have with officers during their fulfilment of their additional programme roles. For instance, the days *health committee members* conduct unpaid work for the medical staff in the clinics. Similarly, among the roles *vocales* have in the programme, they serve as the link between all recipients (or the group they represent) and the medical staff – they deliver messages, discuss any concerns from recipients, and help with administrative work such as collecting the signatures of recipients to record their attendance to meetings.

Indeed, the role recipients have in the programme could be closely related to the frequency of their interactions with the health staff, the terms of their relationship and its influence on wellbeing. This is however an empirical question that is explored in the findings of this dissertation. Ultimately, what this suggests is that together, the official and the unofficial health conditionalities of *Oportunidades-Prospera* create repeated and long-lasting interactions between health officers and programme participants that could influence the power dynamics that occur during their interactions, the nature and quality of the relationship, and the effects of the programme on wellbeing in non-negligible ways. The next section explores what is

currently known about the officer-recipient relationships in the *Oportunidades-Prospera* programme.

## 3.5 Empirical evidence about the implementation of the health component of *Oportunidades-Prospera*

Not surprisingly, research on *Oportunidades-Prospera's* health conditionalities has primarily concentrated in understanding the consequences of deficient implementation procedures (in terms of both poor implementation and inadequate health services) over programme's outcomes (e.g. Sanchez 2008, Bautista et al. 2008). In fact, the low quality of health care services has been identified as one of the major obstacles to programme's effectiveness (CONEVAL 2011) and the cause of the programme's relatively low positive effects on health indicators seen in section 3.3.3 (Gutiérrez et al. 2008).

Most evaluations have recorded that although the access and use of health services has increased as a result of the implementation of *Oportunidades-Prospera*, serious deficiencies both in quantity and quality of healthcare provision remain (Escobar Latapí and González de la Rocha 2000). These include challenges in administrative or procedural issues such as high workload for staff and insufficient personnel, incorrect application of medical procedures, and lack of medicines[37]. For instance, the OECD has shown that Mexico has an average rate of 2.2 physicians and 2.6 nurses per 1,000 inhabitants, figures that are well below the OECD averages of 3.2 and 8.8 respectively (OECD 2014)[38]. The number of patients has also risen dramatically in the last decades mainly because of the conditionalities of *Oportunidades-Prospera*, while investment in health clinics and hospitals has also increased but not at the same rate (Adato et al. 2000a).

In terms of structural issues on health provision, Gutiérrez and colleagues (2008) found that health care units often suffer from energy cuts, 30% do not have access to tap water and 50% to sewage. The average distance between the health clinics and larger units with better medical capacities was 32 kilometres or 1 to 4-hour travel distance, and only 10% of clinics have ambulances. There was a significant shortage

[37] The type of healthcare provider is also an important factor in the low quality of health care. CONEVAL (2011) found that the health clinics ran by the Mexican Social Security Institute (*IMSS-Prospera*) are better equipped and have more resources than the clinics ran by the Ministry of Health (*Secretaría de Salud*).
[38] These numbers might drop significantly for rural areas.

of regular physical surveying tools such as scales and thermometers. More importantly, however, most clinics reported not having the necessary supplies to monitor the programme's key health conditions such as diabetes and high blood pressure or provide prenatal care.

The need to improve medical attention in rural areas has been especially emphasised. It has been found that clinics' opening hours vary significantly between localities. Some clinics only offer services for short hours during the day, while others for no apparent reason do not open at all for days and in some cases although the clinic is open, doctors are not around during work hours (Bautista et al. 2008, Adato et al. 2000a, Skoufias 2005). These issues increase recipient dropout rates (Álvarez et al. 2008) and promote a continual reliance on private medical attention that involve higher economic costs to families, paradoxically reducing the income effect intended by the cash transfer (Escobar Latapí 2000).

Escobar Latapí and González de la Rocha (2000) observed, however, that many of the reasons behind deficiencies in the quality of health care are more related to the willingness of health officers to provide a proper service than to administrative or resource deficiencies. Gutiérrez and colleagues (2008) evaluated quality of care based on the procedures conducted by the health staff during implementation and their capacities to transform them into effective service delivery. Their results suggest that only a small percentage of staff performed the expected routine procedures and tests such as pelvic and breast exams for women, urine tests for diabetics and general lab tests. After further exploring the reasons behind these omissions, they found that 59% of staff reported not requesting lab tests because they did not considered it necessary and only 23.6% because they did not have access to them (ibid).

Indeed, not all issues of quality seem to be dependent on the availability of resources and instruments but by the way health staff choose to conduct their consultations and examinations. For example, despite the large incidence of respiratory problems, fever and diarrhoea in children and the importance given to children's health by the programme's established procedures, only 62.9% of physicians reported evaluating the presence of cough and fever during a consultation, 3.8% the presence of diarrhoea and only 5.2% monitoring feeding practices (ibid).

Overall, these results suggest that although some of the minimum required procedures are conducted, health staff does not always undertake the necessary medical revisions and counselling procedures that constitute a proper health

consultation given the standards of both the national health institutions and the *Oportunidades-Prospera's* conditionalities. Indeed, most health staff (67% physicians and 50% nurses) reported not consulting the programme's procedures guidebook as a source of information but did report having received training from the programme (Gutiérrez et al. 2008). These findings continue to stress the importance of paying attention not only to the quality of the services but to the nature and quality of the relationship between officers and recipients.

Despite the long list of studies that have attested the still insufficient quality of health services provided by *Oportunidades-Prospera*, only a handful have explored the quality of officer-recipient relationships themselves. These findings have mainly come from qualitative studies (e.g. Saucedo 2013, Campos 2012, Streuli 2012, Molyneux 2006). One of the most notable conclusions is that recipients consider the quality of their relationship with officers as a significant aspect of the process of policy implementation. For instance, in a qualitative study, Saucedo (2013) found that whereas the programme's participants were well aware of the poor health services received, most of their complaints were related to what they considered lack of courtesy experienced during the programme's health check-ups.

These negative interactions with officers appear to be especially critical for indigenous recipients. According to Campos (2012) indigenous people have less access to the programme's health activities not because their localities do not have a health clinic due to the remoteness of some of their communities, as is usually believed. Instead, this is primarily a consequence of the attitudes and treatment offered by officers such as lower quality of medical care, mistreatment, abuse and discrimination. This data gains significance when contextualized with findings published by the World Bank that revealed that the large poverty gap between indigenous and non-indigenous is explained by the lower access to services and education of indigenous groups[39] (Garcia-Moreno and Patrinos 2011). Furthermore, according to the national Council for the Prevention of Discrimination (CONAPRED), 27.1% of indigenous groups report feeling they do not have the same opportunities to receive quality health care (CONAPRED 2011). This is particularly important since this dissertation will subsequently discuss the differential experiences of indigenous and non-indigenous recipients in the two sites of this research.

[39] CONEVAL (2010) has found that 79.3% of indigenous people fall below the national poverty line and of these 40.2% are extremely poor.

Moreover, issues of abuse of power have been documented in previous research on *Oportunidades-Prospera's* health implementation in general but predominantly in rural areas (see Smith-Oka 2014, Campos 2012, Gutiérrez et al. 2008; Sánchez López 2008). Escobar Latapí (2000) recorded in an extensive qualitative study that health staff used threats of expulsion from the programme (and carried them out) to force women recipients to accept undergoing a pap smear. In rural localities in Chiapas and Oaxaca, Agudo Sanchiz (2012) found that the health officers considered recipients to have the 'duty' of granting them a certain amount of work hours within the clinic through the *faenas,* even though these have never become an official conditionality. He also finds that officers threaten recipients with reporting them as absent in the otherwise official conditions of *Oportunidades-Prospera* if they do not comply with these unofficial requisites. This same author documented how officers informally adapt the official rules of the programme in many instances. For example, there is evidence that some officers abuse their power by directly imposing economic fees to recipients when they miss an appointment or workshop (official conditionalities) even though these penalties are not stipulated in the programme's official protocol. Hence, the frequency of this practice and the destination of the money lie at the discretion of the officer.

This process of implementation lends *Oportunidades-Prospera's* health activities to be misused, dangerously translating the programme's discourse of co-responsibility into one of obligation and punishment that may cause significant unintended consequences on people's wellbeing. Given these practices and uneven power relations between officers and recipients, Agudo Sanchiz (2012) rightly questions the capacity of *Oportunidades-Prospera* of promoting the agency and participation of recipients intended in its design and advocated by some evaluations (e.g. Barber and Gertler 2010). Instead, he argues, that these power relations "rely on a different notion of reciprocity that is essentially based on clientelistic practices in which patrons dispense favours in exchange of the gratitude of their clients to guarantee the desired 'outcome' of the policy" (p.1).

A small number of empirical studies have built on this understanding of officer-recipient relationships as embedded in problematic conditions of asymmetric reciprocity and hierarchy. Smith-Oka (2013) argues that these conditions cannot be separated from the contrasting identities of both actors within and outside the programme. In a further publication focused on obstetric relations between physicians and female patients in public hospitals in Puebla, Mexico, Smith-Oka (2015) argues

that these conflicting identities and the larger historical processes of social and ethnic hierarchy facilitate officer's exercise of what she defines as 'microaggressions'.

'Microaggressions' are defined by Smith-Oka (2015) as "subtle insults and demeaning behaviour typically aimed at [problematic others] that reflect and enforce the perpetrators' perceptions of their superiority" (p.9). Particularly in this health context, she identified four forms of 'microaggressions': microinsults, microassaults, microinvalidations and corporeal microaggressions. These involve forms of verbal aggressions, reprimands, physical mistreatment and passive aggressive teasing that reflect the physician's negative stereotypes and labels towards patients' identities, lifestyles, roles and preferences. In the context of her research, physicians often described their patients as lazy, deceitful, disorderly, non-compliant, ignorant and sexually loose. Microaggressions are used to cause shame on patients, making the medical encounter easier for physicians by causing a submissive and compliant behaviour from patients and reinforcing the social divide between them.

Some studies have found that the systematic acts of mistreatment, aggression, and power struggles that occur during these interactions are significant for the wellbeing of recipients, although they have not been explored in the context of *Oportunidades-Prospera*. For instance, the large qualitative study conducted by Molyneux and Thomson (2011) on CCTs in Peru, Ecuador and Bolivia found that female recipients often expressed a lower sense of self-worth, agency and empowerment when the interactions with health officers involved violence, shame, discrimination and negative labelling. Although this study does not explicitly use a wellbeing approach, its results begin to display the possible wellbeing implications of this problematic relationship. Similarly, as mentioned earlier, Samuels and Stavropoulou (2016) who were using the IWB approach to analyse their qualitative data from unconditional cash transfers in the Middle East and Sub-Saharan Africa, showed that feeling mistreated, stigmatised and shamed by programme implementers reduced the recipients' sense of competence and self-worth.

The former description of what could be considered a problematic relationship at least, contrasts quite strongly with the empowering aspirations of the programme. For instance, the original design of *Oportunidades-Prospera* explicitly placed as an objective the empowerment of their recipients' (particularly women):

> *PROGRESA seeks to improve the condition of women and empower the decisive role they play in family and community development. The aim in this regard is to satisfy their healthcare and nutritional needs, while providing them*

> *with information and skills to promote their advancement. The focus in all cases is to ensure that mothers are the depositories and holders of all economic benefits of their households* (PROGRESA 1997, cited in Adato and Roopnaraine 2010a, pp.288-9).

The concern for women's empowerment within the family and the community that the programme shows in this quote is intrinsically valuable. However, it also shows the typical omission of the programme's own role in the (dis)empowerment of their recipients through different processes, including programme implementation. In social programmes and development initiatives there is still a tendency to only look outwards to the 'field' or the 'recipients' for things that need to be fixed. Yet, the potential empowering effect of *Oportunidades-Prospera* cannot be known without a full analysis of the relationships that the programme itself is fostering and forcing recipients to engage in. This section has showed that, at the implementation level, the relationships with front-line health officers could neutralize some of the potential empowering outcomes of the programme.

This review exposes that the implementation of *Oportunidades-Prospera* through front-line health officers can thwart the effective delivery of services and distort the original objectives of the programme stated in the design and discourse of co-responsibility. A few studies also problematize the quality of their relationship with recipients by analysing the role of identity, power abuse, discrimination and aggression that can be exerted during the delivery of the programme and find some noteworthy wellbeing effects. Quality of relationships with officers seem to be significant for recipients, yet, empirical research is required to determine the ways in which they contribute to their wellbeing. Arguably, what makes the evaluation of the officer-recipient relationship crucial is their possible long-term and unintended effects over the wellbeing of recipient families.

## 3.6 Conclusion

The objective of the *Oportunidades-Prospera's* health component is to reduce the incidence of preventable diseases through the delivery of medical consultations and health talks. The evidence confirms that officers are achieving some of these policy goals. Yet, this chapter has argued that policy implementation is not only about delivering a service (e.g. applying a vaccination or offering medical consultation). It is

also about what happens in the process of receiving it, a process in which the interactions between front-line officers and recipients have a fundamental role to play.

This chapter has exposed that the implementation of *Oportunidades-Prospera* through front-line officers can thwart the effective delivery of services and distort the original objectives of the programme as stated in the design and discourse of co-responsibility. They also can have noteworthy implications in the wellbeing of recipients, which should be the final aim of every social programme. The little research that has been conducted on the quality of this relationship and the social processes that occur during interactions (e.g. power abuse, discrimination and aggression) suggest some noteworthy implications for wellbeing that need to be systematically studied. Scrutinizing this relationship and its effects for wellbeing could show important implications of social policies and programmes over people's lives that are usually unaccounted for in typical policy evaluation procedures. This is where the contribution of this dissertation lies. Next chapter presents the methodology proposed to achieve this aim.

# 4. Methodological Framework: Wellbeing and relationships through a mixed-methods approach

## 4.1 Introduction

The aim of this dissertation is to scrutinize the significance of officer-recipient relationships for the wellbeing of *Oportunidades'* recipients. However, the choice of methods and conceptual frameworks for this task need to be able to capture the nuanced interconnections between wellbeing and relationships that have been discussed in chapters two and three. Therefore, this chapter defends the use of a mixed-methods approach and the Inner Wellbeing (IWB) model to respond to the research questions of this investigation.

This chapter commences by providing a justification for a mixed-methods approach drawing on the limitations of taking a single method and the benefits of combination specifically in wellbeing research. This is followed by a discussion of the way in which this dissertation will mix methodologies, including the choice of critical realism as the philosophical paradigm and the form in which the methods are combined. The chapter ends with a description of the research strategy undertaken. This section explains the rationale for choosing the Inner Wellbeing (IWB) model for the purposes of this research. Then, the qualitative and quantitative studies are presented separately, including a description of the methodological tools, the selection of the research samples, and the piloting and fieldwork processes.

## 4.2 Research methods in wellbeing research, a case for mixed-methods

In recent years, many academics have come forth in favour of combining methodologies from different standpoints. For instance, in policy-evaluation research (e.g. Adato 2007, Devereux et al. 2013, Ravallion 2009, Kanbur and Shaffer 2005), research on client-agent interactions (Simmons and Elias 1994) and in the wellbeing literature (e.g. Roelen and Camfield 2015, Jones and Sumner 2009, Camfield et al. 2009b, Fattore et al. 2007, White and Jha 2014, White et al. 2016). In the realm of policy, Devereux et al. (2013) argue that introducing mixed methodologies permits observing programme processes and the social dynamics behind their outcomes that cannot be observed using quantitative methods alone. In turn, from the literature exploring relationships between client and officers in health contexts, Simmons and Elias (1994) argue that mixing qualitative and quantitative tools allow observing the meaning behind client-officer interactions rather than only focusing on their quantifiable characteristics such as their frequency. Finally, wellbeing research is

increasingly recognising the value of qualitative methods for uncovering the subjective nature, social processes and contextual embeddedness of wellbeing, as well as for improving measurement accuracy and relevance. Although mixing methodologies can be justified from all these literatures, what is particularly central for this dissertation is to understand its relevance for studying wellbeing.

### 4.2.1 Quantitative Methodologies: Advantages and Limitations

For a long time, surveys and statistics have had the utmost credibility in the social sciences - including wellbeing research - and in public policy. This has implied that for any empirical study that wishes to influence both the academic world and public practice, quantitative instruments are almost an unavoidable requirement (e.g. Adato 2007). There is of course fair justification behind the ample use of quantitative methods. As widely recognised, these instruments are useful for specifying associations and uncovering the wider patterns behind social phenomena. In wellbeing research, the possibility of quantifying subjective experiences has provided knowledge of the many factors that are associated with people's own evaluations of their lives in different nations and contexts (e.g. OECD 2013, Helliwell et al. 2013, Rojas and Martinez 2012). These measurements could be a promising tool for designing and evaluating wellbeing-driven policies at the local and national level, although their policy implications have not yet been fully explored (e.g. ONS 2011).

Quantitative methods transform reality into observable and measurable concepts that reflect their positivist stance. Positivism sees facts about social phenomena as something that exists or is already there and thus the researcher has the task of collecting and organising these facts through some kind of instrument. This methodology generally employs structured interviews, predetermined response options as well as random and large samples to collect these measurable data so it can be appropriately analysed and generalized using statistical techniques.

The appearance of objectivity, formalization and systematization of quantitative methods hide, however, non-negligible challenges that remain in wellbeing indicators and that are particularly relevant for this research project. The issues typically discussed in the SWB literature are related to measurement and social desirability biases such as people's adaptation to positive or negative life circumstances (Frederic and Loewenstain 1999), issues of social comparison in which people evaluate their life based on how their life is going in contrast to the life of others (see

Kahneman and Tverskey 1984), and cultural differences in the way questions and categories are understood and responded to (Diener et al 1999, Diener et al. 1995). Yet, it appears that some models and indicators tend to be more prone to these biases than others. For example, researchers have showed that the global questions of happiness and life satisfaction are more vulnerable to biases related to mood, weather, personality or circumstances than multi-item or domain-specific. The researchers suggest that one reason for this is that responding to global indicators requires significantly more information and complex cognitive judgements (see Schwartz and Strack 1999, Diener et al. 1999).

Beyond limitations in measurement, the aspirations for universality, objectivity and generalizability usually tied to quantitative methods also conceal the problematic use of wellbeing approaches in different contexts since the models and indicators often are culturally specific and inappropriate for contexts other than where they arose. For instance, Christopher (1999) argued that the domains in Ryff's model of Psychological Wellbeing (Ryff and Keyes 1995) are inevitably linked to white, North American values and assumptions about the good life that are not necessarily shared in other contexts. The domain of autonomy is a good example. Ryff and Keyes (1995) define autonomy as being "self-determining and independent, able to resist social pressures to think and act in certain ways, regulates behaviour from within, evaluates self by personal standards" (p.727). This could be interpreted as a culture-bound definition of autonomy as it echoes ideas of independence, individuation, or separateness that might not be reflective of how autonomy is exercised in other cultures (also Kagitcibasi 2005, Devine et al. 2006)[40].

Although the global happiness and life satisfaction questions have been praised for not determining the meaning of wellbeing and thus being more adaptable to different cultures (e.g. Oishi and Diener 2003), these indicators are not immune to biases. For example, Wierzbicka (2004) highlighted the difficulty of translating happiness from English to other languages, because what it means and how it is used can vary between cultures and social norms. In turn, Camfield (2004) reported how research by the WeD group in two developing contexts - Peru and Thailand - doubted the usefulness of life satisfaction since people in these contexts do not usually have control over certain aspects of their lives. This situation prompted people to offer a *defeated 'satisfied'* answer that did not truly reflect their circumstances and experiences. As she rightly argues, "Although being happy and/or satisfied with life

[40] A similar issue occurs in the domains of personal growth and self-actualisation.

are intrinsically valuable states, and ones that have been neglected in development (Clark 2000), we cannot presume that they have the same meaning or priority in every country or situation" (Camfield 2004, p.7).

On the whole, the aforementioned measurement and cultural limitations of quantitative measures of wellbeing raises doubt about their application across significantly different social groups. This stands quite contrastingly with the (diminishing but lingering) tendency to develop and test self-report indicators in Western/Northern countries or with samples composed of educated - e.g. university students - and urban populations. Indeed, much of what is currently known about wellbeing indicators is sustained by empirical studies conducted in these specific kinds of groups, thus questioning their applicability for non-western, non-urban, illiterate and indigenous groups that characterise the participants of this investigation. Ultimately, solely using quantitative indicators of wellbeing in this form might obscure rather than illuminate the wellbeing experiences of certain population groups.

There are also aspects of social phenomena that are difficult to measure since they do not constitute simple observable facts about wellbeing but can be dynamic, ambiguous, interpretative or even contradictory. This is significant for this specific research project since, as the analysis in chapter two exposed, many intricate linkages between wellbeing and social relationships that were salient in qualitative studies (such as power, conflict, negotiation and the coexistence of positive and negative aspects of relationships) were largely unaccounted for by the traditional quantitative approaches of SWB and PWB. One of the reasons for this neglect could be the difficulty of measuring these aspects of relationality given that quantitative indicators tend to require simplified unipolar items to reach meaningful statistical results.

As mentioned above, the difficulty of measuring certain aspects of social relationships has also been underlined in the literature studying relationships between client and officers in health contexts. Simmons and Elias (1994) found that responses to a satisfaction with staff question in a health setting were often in dissonance with what was captured through qualitative tools. People tended to evaluate interactions more positively in surveys than in interviews. The authors interpreted this as an inability of quantitative tools to capture the meaning behind these interactions as well as a 'courtesy' bias that is recurrent in quantitative tools (also see section 8.3.2). These findings reaffirm Wilk's (1999) compelling claim that "any indicator no matter how clever is going to miss an essential quality of what needs to be measured" (p.92).

The difficulty of capturing wellbeing and social relationships through quantitative indicators does not imply that they should not be used. Rather, this issue and those of cross-cultural application and measurement biases point towards the value of complementing this methodological perspective with the more flexible approach of qualitative methods.

### 4.2.2 Qualitative Methodologies: Advantages and Limitations

In contrast to quantitative, qualitative methods seek to collect in-depth data about the attitudes, perspectives and experiences of a relatively small but well-defined sample with the aim of observing the multifaceted and dynamic dimensions of the subject under study (Carvalho and White 1997). It is customary to identify qualitative methods with an interpretivist approach, which often takes a constructionist view of the social world. It is interpretivist for its concern with meaning, specifically, the meaning that social phenomena and social action has for the actors involved. Interpretivism also stresses that various meanings about the same reality can exist (Bryman 2008). Thus, qualitative methods suggest that it is through an examination of the interpretations and interactions of its members that the social world can be known (see also Patton 2002; Silverman 2006). This situates the context, social relationships and the diversity of people's perspectives at the heart of qualitative research; an outlook that goes hand in hand with the purposes of this project of understanding the role of a particular kind of social relationship in the subjective wellbeing of policy participants.

Most qualitative explorations of wellbeing come from the fields of development, sociology and anthropology (e.g. Calestani 2009, Jiménez 2008, Devine et al. 2008, Thin 2005, Fischer 2014)[41]. Camfield and colleagues (2009b) offer an interesting analysis of the value of a qualitative approach in wellbeing research in developing countries through a series of empirical examples. Ultimately, they suggest that qualitative methods provide "holistic and contextual understanding of people's perceptions and experiences" (p.5). Therefore, by giving priority to people's *situated interpretations* of their wellbeing and allowing them to use their own language, narratives, and values, qualitative methods can observe those essential aspects of wellbeing that are difficult to measure or break down into 'objective' domains or

[41] Although less frequently, qualitative methods are also used to conduct research from a SWB perspective (e.g. Ponocny et al. 2015, Tonon 2015).

unipolar indicators. These include the processes and meaning of wellbeing, such as how it is dynamically interrelated and grounded in people's values, aspirations, culture, social interactions and power relations (see also White and Pettit 2004).

In addition to the intrinsic value of qualitative methodologies that is rarely exploited in wellbeing research, they hold an instrumental value that is essential for this field. For instance, research from quality of life (e.g. Camfield and Ruta 2007, Roelen and Camfield 2015), health (e.g. Bowden et al. 2002), child wellbeing (Jones and Summer 2009), and psychosocial wellbeing (e.g. White and Jha 2014) has shown the value of qualitative tools for generating and validating subjective measures within distinct populations. In contrast to quantitative, qualitative methods can observe how people respond to the measures and the extent to which they are actually conveying something significant for them. Camfield and colleagues (2009b) cannot put more clearly the value of using qualitative methods to design quantitative indicators:

> (…) *improves the accuracy of measurement. Qualitative research can make measures more comprehensible and relevant to respondents, provide contextual information to explain particular outcomes, and most importantly, ensure that the 'stylised facts' such as the 'a dollar a day' metric that influence international assistance are based on measures of what matters* (p.7)

Indeed, there are essential benefits of moving beyond the well-accepted view that qualitative data is useful for providing contextual information to the numbers. For Camfield and colleagues (2009b), the instrumentality of this method includes the possibility of shifting the focus from the abstract measures to the respondents. In other words, instead of only designing measures that go well with the theory, the objective is using people's perceptions within the context to construct these indicators and interrogate their validity. Using qualitative data in this way not only helps understand what the measures mean to people and how they respond to them in different settings, but also improves their accuracy by ensuring they are based on what matters to the participants. Ultimately, this approach avoids taking a universalist approach to the study of wellbeing which is deemed to be especially controversial by some (e.g. Christopher 1999).

Of course, qualitative methodologies are not without their challenges. For instance, interacting more directly with the research participant implies that the data obtained

is co-constructed between the participant and the researcher[42]. Nonetheless, qualitative researchers have emphasised for decades the importance of being reflective about the researcher's role in this process as well as in how the data obtained is interpreted and analysed. Another challenge of qualitative research is the scope of the analysis of the data since, given the large amounts of text in qualitative research, it tends to focus on the shared themes present in the data. This reduces the possibility of identifying the diversity and variability in experiences for which quantitative methods can be particularly advantageous with the employment of statistical techniques.

The advantages and disadvantages of each methodological approach in wellbeing research imply that quantitative and qualitative methods are *indispensable complementary* means for this research project. Their complementarity is emphasised principally because both methodologies are able to appraise essential but distinct aspects of wellbeing experiences and social relationships. The capacity of qualitative methods to capture complexity, social structures and situated interpretation is an essential counterpart to the ability of quantitative methods to accurately observe its general shape through subjective indicators. As a result, this dissertation introduced a mixed methods approach for the examination of the research questions presented earlier.

## 4.3 Mixed-methods

Mixed methods (MM) research has been defined as "research in which the investigator collects and analyses data, integrates the findings and draws inferences using both qualitative and quantitative approaches or methods in a single study or programme of inquiry" (Tashakkori and Creswell 2007, p.4)[43]. This scheme originated from a critique of the conventional separation - to the point of antagonism - between qualitative and quantitative inquiry in social sciences (Schwandt 2000). For that reason, the basic principle of MM is that of integration, arguing that both qualitative and quantitative approaches are useful to address many research questions in social sciences (Johnson et al. 2007).

[42] This also happens in survey research but not in the same way since it is the researcher's a priori defined questions and answers that fix the way participants can communicate their perspectives and experiences.
[43] Some debates remain about how best to define mixed methods and what are its philosophical implications (e.g. Tashakkori and Teddlie 2003, Greene 2007).

The most commonly mentioned advantage of MM is the possibility of combining the strengths of the instruments while reducing their weaknesses, which in turn permit drawing out better conclusions than would be possible using either method alone (e.g. Greene et al. 1989, Johnson and Onwuegbuzie 2004, Johnson et al. 2007). However, mixing methods is about much more than simply combining techniques, it involves dealing with various challenges and tensions in the process of mixing[44]. Indeed, proposing mixing methods is attached to two important discussions: (1) what is the most appropriate philosophical paradigm for this methodological approach and (2) how to best combine the contrasting approaches of quantitative and qualitative methodologies.

### 4.3.1 The philosophical paradigm

In relation to the first discussion, Teddlie and Tashakkori (2009) define "paradigm as a worldview, together with the various philosophical assumptions associated with that point of view" (p.84). In other words, this worldview comprises ontology, epistemology, and methodology. There is no single philosophical paradigm behind mixed-methods (for a review see Hall 2013, Tashakkori and Teddlie 2003, Cresswell and Plano Clark 2007). The debates often focus primarily on pragmatism (see Johnson and Onwuegbuzie 2004), however, recently critical realism has received increasing attention (see e.g. Maxwell and Mittapalli 2010, Sayer 2000).

*Pragmatism* is a paradigm that focuses on 'what works'. As its name suggests, the main interest of pragmatism is solving practical problems of social research and thus concentrates on choosing the methods based on the research questions and the purpose of the investigation rather than engaging in a reflection about the nature of knowledge (Hall 2013). As Morgan (2007) described succinctly, "it is not the abstract pursuit of knowledge through 'inquiry' that is central to a pragmatic approach, but rather the attempt to gain knowledge in the pursuit of desired ends" (p.69). While pragmatists acknowledge the role of the researcher's values in the interpretation of results, they claim that qualitative and quantitative methods are not intrinsically connected to a specific philosophical paradigm avoiding the debate about the

[44] This dissertation does not enter into a lengthy theoretical discussion about the tensions in mixing methods. For some takes on this refer to Kanbur and Schaffer (2005) on epistemological and normative issues; Bryman (2007) on issues of integration.

contradictions in the paradigms behind the methods (Tashakkori and Teddlie 2003, Maxwell and Mittapalli 2010).

In contrast to pragmatism, *critical realism*[45] (CR) originated from the recognition of the impoverished approach of traditional paradigms to social science. Its main purpose is thus to reconcile both, the interpretative position typically associated with qualitative research and the positivist stance typically associated with quantitative research. This implies that CR is grounded in reality but gives especial relevance to human agency and social structures in the construction of that reality (see Groski 2013). Neff and Olsen (2007), who developed a convincing case for a critical realist approach in wellbeing research, describe CR as a paradigm that proposes social phenomena as dynamically constructed through social values, meanings and perceptions but at the same time endorses explanation as a reasonable aim of social research. For critical realism, to explain social phenomena is to identify the structures and powers that construct it. It too recognises that the knowledge resulting from empirical research only entails provisional and imperfect descriptions of those structures and powers, while not going to a full social constructionist position that would state that there is no ultimate reality at all (Groski 2013, see Zachariadis et al. 2013 and Maxwell and Mittapalli 2010 for good reviews of critical realism in mixed-methods research).

Despite the extensive use of pragmatism in mixed-methods research, this dissertation takes a critical realist stance for two reasons. Firstly, a general argument. Notwithstanding the many strengths of pragmatism (see Tashakkori and Teddlie 2003), this paradigm underestimates the effect of philosophical assumptions on research methods (Maxwell and Mittapalli 2010, Bryman 2007). Instead, CR distinguishes itself by highlighting the importance of being reflective, clear, and consistent about the philosophical stance taken (Hall 2013). Indeed, being explicit about the ontological and epistemological assumptions behind the research practice is fundamental for they describe how the researcher understands the world and reality, and how she thinks knowledge can be obtained and truth defined. These stances should be particularly clear in a mixed-methods study as they affect the priority given to each of the methods employed and to the data obtained through them. As explained next, in this dissertation both methodologies and their finding were given equal weights and were analysed in their own terms.

[45] There are many versions of critical realism. Some classical texts include Bhashkar (1975), Archer et al. (1998), and Sayer (2000).

Secondly, an ontological argument. The richer interpretative approach within critical realism underscores the relevance of subjective interpretation. Yet, it detaches from the psychological embeddedness of subjectivity traditionally endorsed by wellbeing approaches, and instead resituates it within the social world. Neff and Olsen (2007) represents the ontological position of critical realism as 'depth ontology' which,

> *theorise[s] the human psyche… as being partially shaped by the person's experiences with society, and hence as saturated with social phenomena... there is no denial here of the special essential character of human psychological being, but there is a refusal to reduce it to a psychological essence* (p.53).

Critical realism thus permits socializing the subjective and seeing it as partly shaped by people's experiences in a particular time and place (see also Maxwell and Mittapalli 2010). The implications of the critical realist's depth ontology in wellbeing research according to Neff and Olsen (2007) is that it would understand wellbeing as real, as something that can be experienced and felt, that people can report or reflect on, and has real causes and effects, although we can only imperfectly observe them. However, at the same time wellbeing is not a homogeneous reality as it can be dynamically co-constructed in larger social norms, cultures, institutions and in often power-heavy interactions with others.

Taking a critical realist stance has thus three important consequences for the way this dissertation was conducted. Firstly, a critical realist approach permitted mixing methodologies in order to maximize explanation of the research questions. Secondly, it underlines the importance of being reflective about the ontological and epistemological assumptions behind the research strategy employed. I have sought to achieve this by briefly examining the underlying assumptions behind quantitative and qualitative wellbeing research, and justifying my choice for a critical realist stance. Thirdly, it implied a more rounded approach to the understanding of subjective wellbeing and of its inter-linkages with the social context in which people live.

Although mainstream wellbeing approaches implicitly take the positivist stance given the dominance of quantitative thinking in the field, critical realism is not entirely new in wellbeing research. For instance, in addition to Neff and Olsen (2007), critical realism has been endorsed by Bevan (2004) and Clark and Qizilbash (2005) in their work concerning human needs and subjective well-being (SWB). Following Neff and Olsen (2007), it could also be argued that although the Wellbeing in Developing Countries Research Group (WeD) (e.g. Gough et al. 2007) does not explicitly discuss their philosophical stance, they get closer to a critical realist perspective in their

conceptualization of wellbeing, the place given to culture and social relationships in wellbeing and their endorsement for mixed methodologies.

### 4.3.2 The level of method combination: introduction to this research design

The second key discussion behind mixing methods is a more practical one and is concerned about how to best combine the empirical techniques. There are distinct ways of mixing. Morse (2003) suggests that research designs can be classified in terms of the sequencing and dominance of qualitative and quantitative methodologies. This results in a series of permutations presented below. Following Brannen (2005), the dominance of a method is represented in CAPITAL letters. In turn, the arrows (>) indicate the sequencing of the methods and the plus (+) sign indicates their simultaneity. These are the possible permutations in a research study mixing quantitative and qualitative instruments:

***Simultaneous designs:***

1. qual + QUAN
2. QUAL + quan
3. QUAL + QUAN

***Sequential designs:***

4. QUAL > quan OR 5. qual > QUAN OR 6. QUAL > QUAN
7. QUAN > qual OR 8. quan > QUAL OR 9. QUAN > QUAL

The research design of this investigation can be described as a sequential approach where both methodologies are dominant and equally important for their own sake. Therefore, this MM research can be best symbolised as: QUAL > QUANT.

The dominance of both methods reflects the equal importance given to each during the design and analysis stages. On the one hand, quantitative surveys and qualitative interviews and focus groups were used to respond to the main research questions of this dissertation and are considered to provide equally valuable information about it. On the other hand, in the analysis stage, instead of giving priority to either set of data, each were examined in their own right while reflecting on their similarities and contradictions.

In this research, since both methods were used to answer the same research questions, the aim of mixing is thus one of complementarity and elaboration. However, this dissertation is not assuming that quantitative and qualitative methods produce qualitatively similar kinds of data. On the contrary, the data obtained from semi-structured interviews and the data obtained from surveys are undoubtedly constituted by the assumptions and methods that elicited them (Brannen 2005). The first can offer a richer and more holistic picture of the participants' wellbeing and relational experiences with the officers at the local clinic, while the second is delimited by the language used, questions asked and answers obtained from participants but can provide a better sense of the larger structural contexts of responses (by gender, locality, and other socio-demographic characteristics). However, together, they permit generating a thicker apprehension of the association between officer-recipient relationships and wellbeing, at the same time as individually corroborating or contrasting the findings of the other. Ultimately, this might also give insights about the advantages and disadvantages of using each method (separately or together) to explore wellbeing and social relationships in this policy context. This is examined in conjunction with the analysis of the results obtained with each method (chapters five to eight).

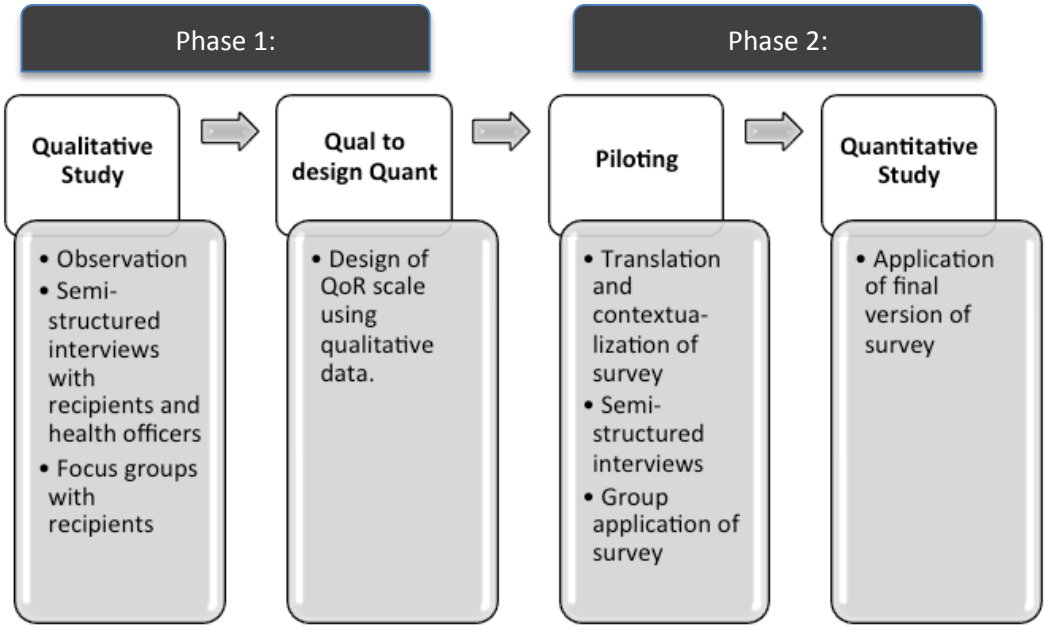
It is important to make a parenthesis here since, of course, comparing the findings of both methods does not negate the possibility of obtaining contradictory results. The fact that qualitative and quantitative instruments can observe partial pictures of the same phenomenon implies that they can generate not only distinct but conflicting findings (Jones and Sumner 2009). For example, as part of the WeD research on quality of life (QoL), Camfield and Ruta (2007) contrasted the findings of the Global Person Generated Index (GPGI) survey and the data collected from semi-structured interviews. Their analysis showed that the overall QoL score and the relative weights given to the various life areas were contingent to the methods through which they were collected (Camfield et al. 2009a). For them, this indicated that respondents expressed the same constructs in different ways depending on the instruments used, the context in which the research was undertaken, and the relationship that was created between the researcher and the respondents (see White et al. 2012b for a similar experience). While this is an important challenge to be considered during the analysis of the data, it also gives added value to the use of mixed-methods.

More importantly, however, this issue underlines that the data collected by distinct techniques should not be taken as objectively correct. Rather, they narrate something useful about the face people want to present about themselves, their wellbeing and

their relationships, given the methods employed and the research context. Conversely, the findings should not be regarded as “truths” or “facts”, but as the result of the dialog between the people involved, and between the concepts and the methods employed. Therefore, the methods have an important role in what is found in the research, and thus they require extensive reflection and validation for the scenario in which the research will develop. This dissertation thus gives especial attention to the implications of the methods on the findings obtained. This stance is in line with the critical realist approach discussed in the previous section.

Continuing with the discussion of the way methods are combined in this research design, the arrow sign (QUAL **>** QUANT) demonstrates how the methods were sequentially applied during the fieldwork process. To explain the sequencing of the methods, however, a brief overview of the research design of this dissertation is needed (this is explained in section 4.5).

**Figure 4.1** Sequential Research Design




The research design involved two sequential stages (figure 4.1). The *first stage* consisted of a period of observation in the health clinics, focus groups and in-depth interviews with recipients and officers currently delivering the health conditions of *Oportunidades*. These scrutinized, among other things, the encounters between recipients and officers and explored the pathways in which these interactions influenced recipients’ wellbeing. The qualitative data obtained from the interviews with the recipient families also served as a basis to design a scale evaluating the quality

of officer-recipient interactions (Quality of Relationships with Officers scale, QoR). The *second stage* consisted of the design, pilot and application of the quantitative survey. The survey included four sections assessing the quality of relationships with health officers, wellbeing, the recipients' affiliation to *Oportunidades* and socio-economic characteristics.

Indeed, part of the utility of the data obtained from the qualitative interviews and focus groups is to (a) obtain an in-depth understanding of how participants defined and experienced their relationship with health officers which served to develop a battery of indicators to measure quality of officer-recipient relationships (QoR); and (b) after designing the quantitative survey, another round of qualitative interviews were used to test the relevance and clarity of the survey questions (piloting). This is the instrumental value of qualitative instruments defended by Camfield and colleagues (2009b) and discussed in section 4.1.2.

### 4.3.3 Final considerations

In sum, by combining methodologies and taking a critical realist stance, this study has a number of benefits. First, quantitative methodologies facilitate providing clear messages to policy-makers while qualitative methods and subjective indicators together allow giving voice to the participant's own perceptions and experiences of their lives and of their relationship with programme officers. Second, quantitative methodologies can offer a larger view of participants' wellbeing and of the officer-participant relationship within and among localities and permit drawing on statistically tested similarities and differences in the experiences between localities. Third, qualitative methodologies can provide an in-depth picture of the processes behind the interactions between officers and participants and understand the meanings of people's assessments of these relationships through the quantitative indicators. Next section presents the research strategies of this dissertation.

## 4.4 The wellbeing framework: Inner Wellbeing (IWB)

This dissertation employs the Inner Wellbeing (IWB) approach as the wellbeing framework guiding the empirical studies. Inner Wellbeing is a psychosocial model of wellbeing designed in and for developing contexts to address issues of policy and development (White 2010). It has its roots in the Wellbeing and Poverty Pathways

(WPP) research project developed at the University of Bath and funded by the ESRC/DFID between 2010 and 2014.

The project had the purpose of exploring the association between poverty and wellbeing in developing countries (www.wellbeingpathways.org). Its theoretical and methodological foundations make bridges between various approaches, including the Wellbeing in Developing Countries (WeD) Research Group also developed at the University of Bath (e.g. Gough et al. 2007) and the Psychosocial Approach of Development and Humanitarian Interventions (PADHI) from the University of Colombo (SPARC 2009).

IWB was the preferred approach for this research project for at least three reasons: (1) its configuration as a multi-dimensional model of wellbeing; (2) its grounding in and for developing countries; and (3) its greater recognition of the social and relational experience of wellbeing. These are explained in section 4.5.

IWB is a multidimensional model composed of seven distinct but interrelated domains that have been found to constitute wellbeing, both theoretically and empirically in two developing countries, Zambia and India (see White 2010, White et al. 2014). The domains are: economic confidence, agency and participation, social connections, close relationships, physical and mental health, competence and self-worth, and values and meanings (figure 4.2). These domains include some of the most important aspects identified in psychological approaches such as competence, self-worth, and relationships (social and close), as well as those advocated in the sociological and development literature such as agency.

In addition to measuring wellbeing through different domains, each domain is assessed by a number of items that capture distinctive aspects of the domain. For instance, the domain of social connections includes items that measure how socially connected the person is and the perceived quality of their social connections. In turn, the domain of economic confidence includes items that measure present and future economic confidence (how they are managing at present and how do they think their children could manage in the future), relative economic confidence (how they are doing compared to others), and the effects of their economic circumstances in their social life.

The key advantage of utilizing this multidimensional approach for this dissertation lies in the possibility of exploring the differential role of officer-recipient relationships in

diverse aspects of wellbeing. Indeed, rather than solely evaluating whether these relationships are positive or negative for overall happiness, for example, the IWB approach permits tracing which domains are more influenced by this relationship compared to others.

**Figure 4.2** Inner Wellbeing Model


Source: Wellbeing and Poverty Pathways Briefing Paper No. 1

This seven-domain model is also grounded in developing countries as it emerged from the development literature and was generated through extensive mixed-methods research in rural localities of the aforementioned developing countries, Zambia (White et al. 2012a) and India (White et al. 2012b). Its foundation in and for developing countries undoubtedly constitutes advancement from approaches like SWB and PWB that were conceptually and methodologically developed primarily on Western values and samples. This is especially appropriate for this dissertation as it was conducted in two impoverished localities of central Mexico.

The IWB approach also recognises the role of culture in what wellbeing means and how it can be measured and thus advocates for the adaptation of the model to the contexts in which it is applied (Wellbeing and Poverty Pathways Briefing No. 1, 2013). Therefore, the wording and emphasis of the items contained in the domains could be localised to this research context through qualitative procedures.

The IWB model is also cornerstone towards a greater acknowledgement of relationships in wellbeing research for several reasons. Firstly, like eudaimonic

approaches, the model includes relationships as constituent aspects of wellbeing in the domains of *close relationships* and *social connections*. They also measure their quality directly. Examples of these items are, “Do you feel there are people beyond your immediate family who you’ll be able to count on even through bad times?” “How much do people in your house care for you?”

Secondly, relationships are also captured indirectly in the domain of *agency and participation*. This domain by definition represents an aspect of wellbeing that is created in and through interactions with others. For instance, feeling confident to voice an opinion in a community meeting or feeling heard by others not only depends on the person herself, but also is created in interactions with others. Therefore, this could be considered the third relational domain of the IWB model.

Thirdly, most domains include items that recognise how these aspects can be experienced in relational contexts, even in those that are usually considered psychological by nature such as competence and self-worth. For instance, competence includes items assessing people’s ability to positively influence others (family and community) and to fulfil duties and responsibilities to the family. Similarly, self-worth includes items on people’s sense of being recognised by others and of having a place in the world. Hence, although this is also a domain-based approach like Ryff’s model of Psychological Wellbeing (Ryff 1989), the domains of IWB are oriented towards a more social understanding of wellbeing rather than primarily psychological processes.

Beyond the relational cast of the IWB’s empirical model, this approach is founded upon two conceptual frameworks that give relationships a greater role in the experience of wellbeing: WeD and PADHI. As discussed in chapter two, the Wellbeing in Developing Countries (WeD) research group proposed a three-dimensional model of wellbeing that places relationality as a key dimension. Indeed, the primary point of agreement between IWB and WeD’s conceptual framework is the understanding of wellbeing as an experience that happens in the interrelation of the material, the subjective and the relational dimensions (White 2010, Gough and McGregor 2007, see figure 2.1). These dimensions are reflected in the definition of *inner wellbeing* behind the IWB model “what people think and feel about what they can do and be” (White et al. 2014).

Following the social justice approach proposed by PADHI, the IWB approach also argues that rather than being a state or a trait, wellbeing involves an active negotiation

that happens in interactions with others at different levels: personal, communal and institutional. These interactions are responsible for creating and reproducing issues of discrimination, marginalisation and power relations that both constrain and facilitate the strategies that people use to be well. Relationships at personal, communal and institutional levels are thus seen to regulate the resources people can have and how they can access and use them, but also their inner wellbeing. This has wider implications for the benefits of a wellbeing approach in the analysis of policy and development interventions as it underlines that the promotion of wellbeing should move beyond people's psychological and personal traits and start to analyse the relational processes that transform people's wellbeing. In the context of *Oportunidades* and the interactions between health officers and the recipient families, this conceptual awareness of the dynamics and power embedded in social interactions is especially important.

Overall, the IWB model has various benefits for the research context and purposes of this dissertation concerned with exploring policy relationships and wellbeing in a developing country. On the one hand, this approach offers a comprehensive and multidimensional model of wellbeing that permits evaluating the role of officer-recipient relationships in different aspects of people's lives. On the other hand, this approach proposes a model that is grounded in and directed to developing contexts, which is ideal for the research setting of this dissertation. Finally, the IWB approach foregrounds relationships and relationality together with a concern for people's perspectives on their lives (the subjective). It also takes a more rounded approach to relationships by explicitly paying attention to how the context, culture, institutions and social relationships co-construct wellbeing experiences through issues of power, exclusion and other mechanisms.

These characteristics of the IWB approach can enlighten both the qualitative and quantitative studies of this mixed-methods research. The IWB model was used as the key framework to measure the wellbeing of *Oportunidades*' recipients in the quantitative study. However, the quantitative model does not include the more dynamic and intricate relational aspects of wellbeing described above - probably as a result of the difficulty of measuring them. This outlook was nonetheless illuminating during the analysis of the qualitative data on the characteristics of the officer-recipient relationship and its intricate role on the strategies recipients used to achieve wellbeing. This is further explained in the coming sections.

## 4.5 Research Strategy

The fieldwork took place between January and September 2013, in two localities of the State of Puebla, Nexpan and Cualcan.

The data collected had the objective of answering the sub-questions of this dissertation. These are concerned with (1) understanding the characteristics of the relationship between recipients and health officers, (2) exploring the shape of the subjective wellbeing of recipients, and (3) scrutinizing the pathways through which this relationship can influence subjective wellbeing.

**Table 4.1** Summary of Research Design

| Method | Instruments | Sample | Description |
|---|---|---|---|
| Qualitative Study (Phase 1) | *Observation (1.1)* | N/A | Familiarise with contexts and observe interactions between officers and recipients in local clinics. |
| | *Semi-structured Interviews (1.2)* | *Recipients*: 15 Nexpan 15 Cualcan | Explore how recipients narrated their interactions with health officers and their role on wellbeing |
| | | *Officers*: 4 Nexpan 2 Cualcan | Analyse how health officers described recipients, their relationship, and their functions in the health clinic and in Oportunidades. |
| | *Focus Groups (1.3)* | *Recipients*: 1 Nexpan 1 Cualcan | Observe how recipients exchanged and produced ideas and experiences about the influence of officers on their wellbeing. |
| Quantitative Study (Phase 2) | Quality of Relationships with Health Officers (QoR) | *Recipients*: 170 Nexpan 142 Cualcan | Scale composed of 14 items and designed based on the qualitative data about the aspects that constituted a positive and negative relationship with officers. |
| | *Inner Wellbeing (IWB)* | | A psychosocial model of wellbeing with a more social emphasis. Define wellbeing as "how people feel and think about what they can do and be" (White et al. 2014). Composed of seven domains measured through 36 items. |
| | *Subjective Well-being (SWB)* | | Measures global evaluations of subjective wellbeing: Life Satisfaction and Happiness |

This section presents a detailed description of the qualitative and quantitative studies conducted. Table 4.1 presents a summary of the research design and the sequencing of the procedures conducted during the fieldwork. The numbers in parenthesis in phase 1 depict the sequencing of the sub-strategies of this phase (this is a more detailed version of figure 4.1).

### 4.5.1 The sample

The fieldwork was carried out in the state of Puebla located at the heart of the country, approximately 100 km east from Mexico City (figure 4.3). Historically, this state has been among the poorest in the nation. According to the National Council of Evaluation of Social Development Policies (CONEVAL), in 2008 Puebla was the third state with highest multidimensional poverty, with 64% of the population living in moderate poverty (3.59 million people) and 18.1% living in extreme poverty (1.02 million) (CONEVAL 2010). As a result, according to government figures, in 2011 *Oportunidades-Prospera* supported approximately half million families (Gobierno Municipal, 2011).

The selection of the communities and participants for this project was guided by the nature of the context. Drawing from the literature presented in chapter two about the political and power-laden nature of officer-recipient relationships, a hypothesis of this project is that interactions with front-line officers flow differently according to the identity of the people involved. For this reason, the socio-demographic characteristics of recipients were significant in the selection procedure. The opening benchmark for choosing the sample was the socioeconomic properties of the localities, urban or rural. Urban and rural localities are distinct in many ways, from the economic activities that predominate, the cultural traditions that linger, to the accessibility to and from the communities in terms of roads, information and access to services. These generate rather diverse realities in which relationships develop and wellbeing is experienced.

**Figure 4.3** Map of Mexico signalling the location of the state of Puebla

Ethnicity was another relevant criterion for sample selection. Indigenous groups in Mexico are the social group most affected by poverty, inequality (CONEVAL 2010), and discrimination (ENADIS 2010), and as seen earlier indigenous and rural localities are particularly discriminated against by health officers in *Oportunidades-Prospera* (Campos 2012, Smith-Oka 2015). Therefore, the quality of encounters could differ depending on the ethnic identity of the actors involved. Although gender could be significant in shaping this relationship, the possibility of gathering a diverse sample in terms of gender was unlikely due to the mechanism of programme delivery directed to women. Hence, considering these criteria, urban/rural divide and ethnicity, two localities from the 217 municipalities of the state of Puebla covered by *Oportunidades-Prospera* where identified. These are called Nexpan and Cualcan for anonymity reasons.

### *Nexpan and Cualcan: Brief descriptions*

Nexpan is a semi-urban locality at the outskirts of the city of Puebla, the capital of the state. The municipality records show that it is formed of 6,959 people of which 356 families were recipients of the programme in 2013. The population is mainly *mestiza* (94.7% reported not speaking an indigenous language), with farming and cleaning households in the nearby cities of Cholula and Puebla as main sources of livelihood for female recipients.

Catholicism and religious festivities and traditions are strongly ingrained in the locality. These often involve large processions, lengthy gatherings with music, food and drinks, and fireworks. These celebrations are coordinated and sponsored every year by elected individuals that perform as church officials throughout the year. While

these celebrations are deep-rooted in their ways of life, in modern times people often commute to the city to work making it difficult to have the time required to attend meetings and organise the celebrations.

Cualcan, in contrast, is a rural and indigenous locality with 97.9% of the population speaking the indigenous language Nahuatl as their mother tongue. Whereas most of the population can speak Spanish as a second language - though not necessarily fluent - not all (especially the elderly) can read and write. The locality has a population of 6,823 people of which 699 families were recipients of *Oportunidades-Prospera* in 2013. Cualcan is located four hours away from the capital of the state, in the northern highlands. Farming (coffee, corn, beans, pepper and fruits) and selling traditional craftwork were the most important sources of livelihood.

This locality has an ancestral culture and traditions that show a clear syncretism between Catholicism and prehispanic customs. The town celebrations happen in September in which for four consecutive days the whole community participates in prayers and recreations of their myths through dances. The celebrations involve many people collaborating in the fabrication of handcrafts, food, and traditional suits for the dancers, who hold special status in the locality.

### *Health Clinics in Nexpan and Cualcan*

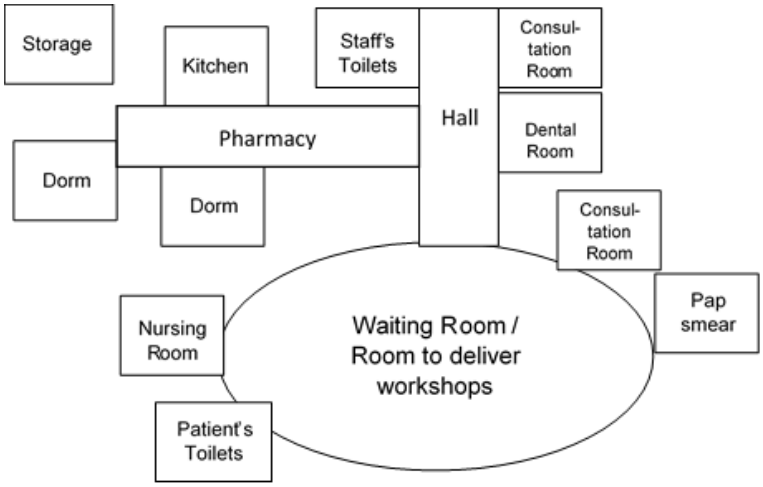
In both localities, the health clinics in which *Oportunidades-Prospera* is delivered were built partly with public funds and partly through collections among the local inhabitants (Tochimani 2015).

The health centre in Nexpan was composed of one waiting room, two medical consultation rooms, one curative and pap smear room, one vaccination room, one dental consultation room, a pharmacy, a kitchen, bathrooms for patients, three bathrooms for health staff, two dorms for a doctor and a nurse, a storage room, a service patio and a parking lot (figure 4.4). At the time of the fieldwork, the health staff included one chief doctor, one intern, two dentists, and two nurses.

The official opening hours were as follows:

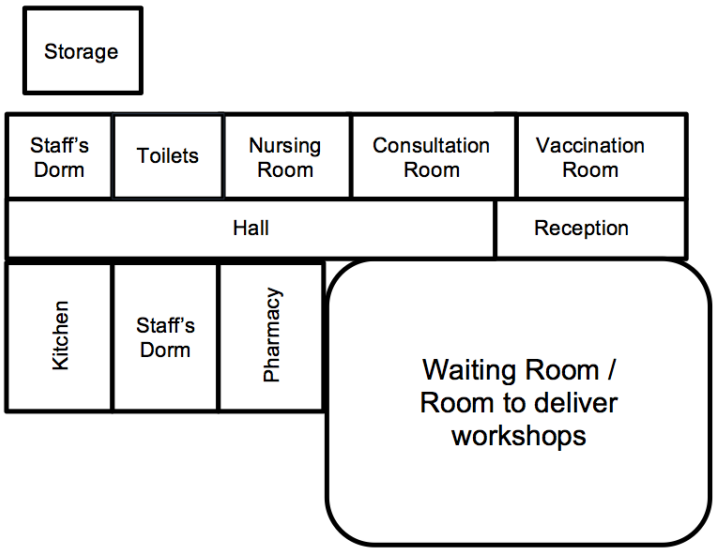
- General medical consultation: Monday to Saturday 8:00 to 17:00 hours
- Dental consultation: Monday to Friday 8:00 to 16:00 hours
- *Oportunidades* workshops: 14:00 to 15:00 hours
- Emergencies: 24 hours.

**Figure 4.4** Map of Nexpan's health clinic




In Cualcan, the health centre was composed of one waiting area, one consultation room, one vaccination room, the pharmacy, one dorm for doctors and nurses, one toilet for staff, one toilet for patients, a storage room and a parking lot (figure 4.5). The health staff encompassed one intern who also performed as chief doctor throughout the year since no permanent doctor was hired by the National Health Ministry, two nurses, and one auxiliary nurse.

**Figure 4.5** Map of Cualcan's health clinic




The opening hours were as follows:

- General consultations: 8:00 to 16:00 hours
- *Oportunidades* compulsory consultations: 12:00 to 14:00 hours
- *Oportunidades* workshops: 14:00 to 15:00 hours.
- Emergencies: 24 hours.

In each locality, the sample was reached through the compulsory monthly health workshops of *Oportunidades* where recipients gathered in the clinic. This method of gaining contact with recipients had the disadvantage that some participants initially linked the research project to *Oportunidades*, although its separation to the programme and the clinic was underlined on several occasions. Notwithstanding, it was preferred due to the time and cost constraints this project faced. Indeed, it allowed making contact with large numbers of possible participants without the difficulty of traveling in a household-by-household basis. The fieldwork lasted eight months in total, four months in each locality.

### 4.5.2 Qualitative Study

The participants of the qualitative study were the recipients (recipients and *vocales*) and health officers (doctors, interns, dentists, nurses) of *Oportunidades*. The qualitative phase consisted of a period of observation in each clinic, semi-structured interviews with health officers and recipients individually and focus groups with recipients.

#### 4.5.2.1 Observation

Observation is a method of data collection that implies the immersion of the researcher in the social setting to gain knowledge of the daily dynamics (Bryman 2008). In this study, observation was mainly employed as an informal device to familiarise with the context of *Oportunidades*, the localities and the procedures in the local clinics. More formally, however, its purpose was to observe how the interactions between officers and recipients took place during the provision of the health conditionalities of *Oportunidades* in the clinics. I mainly acted as non-participant observant during the programme's health workshops and waiting area during consultation hours. But in a few occasions, the head of the clinic asked for help with the workshops since the doctor was too busy to provide it.

A main advantage offered by this method was enhancing my capacity to see through the eyes of the participants and understand their perceptions, customs, behaviours and, of course, their interactions. It also helped to gain access to certain dimensions of the context that were not necessarily salient in the unnatural interaction prompted in a formal interview such as some aspects of the behaviours of officers and recipients

that are buried in their unconsciousness (Camfield et al. 2009a). As Bryman (2008) suggested, as participants got accustomed to my presence, they began to act and interact between each other in ways that they normally would, without being so conscious of being observed.

#### 4.5.2.2 Semi-structured interviews

Conducting interviews with health officers and recipients was suitable to understand - through their own narratives and experiences - how they perceived their relationship and the role of this relationship on wellbeing. Three versions of qualitative interviews have been distinguished (e.g. Silverman 2006), for this research semi-structured interviews were the preferred type as they bear important advantages. Their flexible structure permitted the interviewees to frame and interpret the themes discussed freely, encouraging them to explain their views of the events and behaviours under study with the objective of obtaining in-depth answers (Denzin and Lincoln 2000, Bryman 2008). At the same time, the possibility of maintaining a research schedule with the relevant subtopics to be covered in all interviews ensured some degree of comparability between interviews and localities. One of the most widely recognised limitations of interviews is, however, that the data obtained are the result of the interaction between the participant, the researcher and the context in which the interview takes place. This fabricated scenario makes it impossible to observe the actions of participants (e.g. Silverman 2006). For this reason, this research complemented interviews with observations.

Before each interview, the participant was asked to read and sign a consent form explaining the research's objectives, the procedures of the interview, and their rights to anonymity, confidentiality, to avoid responding any question that made them uncomfortable or to withdraw at any moment of the study without the need of providing justification. Permission was asked to record their responses, reassuring them that all information will be strictly confidential and their identities will be kept in anonymity. When a written consent (appendix A) was not possible, an oral consent was requested. The next sections explain the purposes and procedures of the interviews conducted with health officers and recipients separately.

*Interviews with health officers*

The interviews with health officers examined the way in which officers spoke about recipients and about their relationship with recipients, as well as officers' understandings of their own roles and those of recipients in the health clinic and in the implementation of *Oportunidades'* conditionalities (see appendix B for the interview guide). The central focus was thus not the individual officers, but how they characterised their relationship with recipients. However, given that relationships are a difficult topic to discuss directly, the opening statement focused on officers' experiences working at the clinic and implementing the health conditionalities of the programme. It was in the follow-up questions where they were asked to describe the relationship between officers and recipients (in the abstract) and their perspectives on recipients.

Health officers were recruited by asking for their voluntary participation (only one officer in Cualcan refused to participate in the study). The interviews were always conducted in the local clinics in any space that ensured privacy (usually the consulting room). Of the ten health officers working at the clinics at the time of the fieldwork (all female, 6 in Nexpan and 4 in Cualcan), six officers were interviewed. In Nexpan, these include the director of the clinic, one dentist, one intern and one nurse. In Cualcan, the director of the clinic and one nurse were interviewed. Each interview lasted approximately 45 minutes to one hour.

*Interviews with recipients*

The focus groups and interviews with *Oportunidades'* recipients scrutinised how participants experienced their encounters with officers and explored the pathways through which they influenced wellbeing. No wellbeing approach was used to frame the interviews or focus groups. Therefore, recipients were free to talk about the relationship and their wellbeing in whatever manner chosen. As mentioned above, however, the psychosocial approach of IWB was employed for the analysis of the findings. The data obtained from these methods also served as a basis to design a scale evaluating the quality of the interactions with officers (QoR). This scale is presented in section 4.2.4.1 and further clarified in chapter six (quantitative findings).

The theme with which the interviews with recipients began had the intention of orienting the interviewee around the general subject matter being discussed. The opening statement was: "I want to understand how *Oportunidades* has been

significant to your life and what have been your experiences in the clinic" (see appendix C for the interview guide). The rationale to commence with this general statement is associated with the properties of the method chosen which lets the interviewee free to populate the discussion in whatever manner he/she reads the statement. Moreover, this introductory theme had the additional function of framing people's reflections of their wellbeing around the context of *Oportunidades* and the health clinic.

Analogous to the interviews with officers, the recipient's perceptions of their relationship with officers were scrutinised in the follow-up questions in two ways, indirectly and directly. Indirectly, recipients were asked to characterise what usually happens in a compulsory consultation of *Oportunidades* and what have been their experiences during these consultations and during the workshops that are part of the official conditionalities of the programme. If they acted or were acting as *vocales* or members of the health committee (the unofficial conditionality of the programme), they were also asked to describe their experiences working more closely with the health officers. The terms of their relationship with officers were scrutinised directly by asking: (1) how do you get along with the health officers?, and (2) in what ways do you think that your relationship with the health officers is or is not important for you and your life?

In each locality, 15 interviews were conducted. In Nexpan, three of the 15 participants were *vocales* of *Oportunidades* (all female) and two participants were male. In Cualcan, three participants were or had been *vocales* of *Oportunidades* (all female) and only one participant was male. In terms of procedure, recipients were recruited during the health workshops of *Oportunidades* in which I acted as observer. In the first week, the officers allowed me to introduce myself to all recipients present and explain my intentions to interview them. They were invited to sign up at the end of each workshop and then we set a place, date and time for the interview. The interviews were conducted in any place that was convenient for the participant. In most cases this was their home and in a minority of cases the interview was conducted in a public park or the local school. Similarly, to boost the authenticity of the accounts, most interviews were conducted with the respondent alone. However, this was not possible in a couple of interviews in which the husband asked to be present. The analysis of these interviews was done with an awareness of this and of the effect it could have had on how women responded in front of their husbands.

In Cualcan, participants were given the option of having the interview in Nahuatl or Spanish, and only two of the 15 interviewees chose the former option. In these two cases, a translator[46] was present at all times, although the interviewees themselves frequently switched from one language to another depending on how they felt best to describe their experiences.

#### 4.5.2.3 Focus groups with recipients

As mentioned above, the focus groups shared the overall objective of the semi-structured interviews to explore how recipients perceived their interactions with officers and their effects on wellbeing. However, in contrast to interviews, the defining feature of focus groups is that they generate and analyse interactions between the participants, resulting in a different kind of data (Halkier 2010). Indeed, focus groups uncover how, in a social scenario, people exchange ideas and experiences, choose to articulate their accounts and support or oppose the accounts of others, and in the process produce new ideas through consensus and dissent. However, given that the outcomes of focus groups are importantly determined by the interactions that happen in the process, is essential to be attentive to the group's configuration and the dynamics within each group such as issues of power. For this reason, the size and group composition of the focus groups were carefully chosen.

In each locality one focus group was conducted. In Nexpan 10 female recipients volunteered to participate. This group was composed of two participants who were or had been *vocales* of *Oportunidades*, one that was currently part of the health committee in the clinic and the rest were just recipients. The focus group was conducted in a classroom of the local primary school. In Cualcan, 9 female recipients volunteered to take part in the group interview. This group was composed of two participants who were *vocales* and four were or had been part of the health committee. The meeting was organised in the house of one *vocal* who kindly offered it for the activity. Each focus group was recorded and lasted between 1.5 and 2 hours.

Given the differential role of *vocales* and recipients in the programme, issues of power could have arisen during the focus groups. The most salient of all was that *vocales* were more comfortable expressing their views and had more knowledge about how things worked in the clinic and in *Oportunidades*. These differences were prominent

[46] The translator was a research assistant from the locality who spoke both languages fluently and was currently studying an undergraduate degree in psychology.

between *vocales* and the junior recipients of the programme (in terms of time in the programme). Yet they were blurrier with senior recipients. To avoid certain participants dominating the conversation, as a moderator I encouraged (but never required) the more silent participants to join in. Issues of power or domination, however, were not constant during the conversations. *Vocales* and recipients appeared to feel comfortable voicing their perspectives to the group and to me, and they were respectful of the opinions of others. The focus groups ran naturally in both cases.

The overall objective of the focus groups was achieved through a series of activities and discussions carefully selected (see appendix D for focus group guide). The meeting started with an icebreaking activity in which I presented the aims of the discussion and myself as a researcher, and then asked each person to introduce herself. This was instrumental for participants to get to know each other better and promote a positive environment, as well as to learn key information such as how many years they had been in the programme and whether they have acted as *vocales* or health committee members. After this introduction, two core activities were organised to discuss issues related to quality of officer-recipient interactions and their influence on wellbeing.

Firstly, participants were asked to represent their interactions with front-line officers through a drama enactment. Specifically, they were asked to interpret and describe what happens when they meet with a front-line officer in the clinic during a consultation or a workshop. The general group was separated into pairs. Each pair interpreted either a positive or a negative interaction with a health officer. The participants in each pair chose who performed the part of the health officer and who performed the part the recipient. They also needed to decide on what would be the characteristics and attitudes of each and develop the plot. After each pair interpreted the scenes, all participants were invited to explain what they saw in the scenes, and reflect about how they would feel in those situations or if they have had similar experiences in reality.

The second activity asked participants to reflect and write down in a piece of paper three words/ideas that characterise a positive and negative interaction with officers. After doing this individually, they were invited to collectively rank these words/ideas in terms of which was a more/less important characteristic of a positive and negative type of interaction. Finally, we discussed the resulting rankings together.

#### 4.5.2.4 Analysis of qualitative data

In accordance with the overall aims of the interviews and focus groups of uncovering the relational experiences of recipients and officers, the analysis of the data was based on a discourse analysis approach. Discourse analysis has been defined as the analysis of language 'beyond structure of the sentence' (Tannen 2012). This approach gives greater relevance to the use of language and emphasises that it is through language that the interrelationship between the context, the others, and the self emerge. Indeed, discourse analysis is interpretative and constructivist, acknowledging the embeddedness of meanings in layers of contexts and in negotiated interpretations that accrue from the interaction between the participant(s), the interviewer, and the wider social and political contexts (Abell and Myers 2008, Wetherell and Potter 1988 cited in Talja 1999). Therefore, this approach is ideal for the objectives of this dissertation as it permits not just categorising the surface content of what was said but also the underlying structures and assumptions (the discursive framing).

The data was analysed by focusing on how the participants' discourses presented the other (either the recipient or the officer) and the relationship between them, and how the narratives of recipients constructed their experiences of wellbeing in association with this policy-engendered relationship. This approach is ideal as it leads away from trying to find how relationships affect wellbeing, towards understanding wider functions of relationships within wellbeing accounts.

The ultimate goal of the analysis was to identify patterns of consistency and variation between the accounts produced by all participants. The qualitative data from health officers and recipients were analysed separately since they had different purposes. The analysis commenced with the interviews with health officers and then moved on to the interviews and focus groups with recipients.

All interviews were recorded and transferred onto a password protected computer before being transcribed by the researcher. The transcripts were imported into NVivo (version 8) and read again to check for accuracy before the initial coding and overall analysis.

An *initial coding* was conducted on a line-by-line and interview-by-interview basis. The data that fitted into the existing codes were assigned to the appropriate code. If data did not fit into existing codes, another code was created to better describe the idea it reflected. A second round of analysis was conducted to understand the initial

codes in the larger context in which they were mentioned and to explore any overarching themes that emerged. These wider codes/themes were reviewed and checked a number of times to refine their meaning. In this process, the themes were linked to coded extracts that were used in the final phase of the analysis that involved producing the reports.

### 4.5.3 Quantitative Study

As has been mentioned, quantitative methods predominate in wellbeing research. This is partly for the non-negligible benefits they offer. In the case of this dissertation, the application of surveys permitted identifying those subtle differences and associations between wellbeing and the quality of officer-recipient relationships that statistical techniques can detect. Yet, as has been emphasised throughout this dissertation, quantitative methods have a limited ability to capture certain aspects of the association between these phenomena, such as more relational processes like issues of power, conflict and ambiguity. Hence, this approach is used to answer the same research questions but only focusing on one particular aspect of the officer-recipient relationship, its quality.

#### 4.5.3.1 Instruments

Three key scales to measure wellbeing and quality of relationships are the basis of the quantitative analysis. The following is a description of each.

*Inner Wellbeing model (IWB)*

The psychosocial approach of Inner Wellbeing (IWB) is the main model used to assess the wellbeing of the recipients of *Oportunidades*. In the survey applied for this study, the IWB scale (White et al. 2014) was composed of 36 items. This scale measures 7 domains of wellbeing which include (1) Economic Confidence, (2) Social Connections, (3) Close Relationships, (4) Agency and Participation, (5) Physical and Mental Health, (6) Competence and Self-worth, and (7) Values and Meaning. Each domain contains five items (except the Close Relationship domain which includes 6 since the piloting and contextualisation process suggested that another question was necessary) that aim to capture different aspects of what people think and feel about

what they can do and be (White 2013). Some examples of the items are: For the Close Relationships domain, “When you need to talk about something that is important to you, is there someone you can go to?” For the Agency and Participation domain, “How often do you feel that you have the freedom to make your own decisions?” (see table 7.2 for all items). All indicators are ordinal and measured in a 5-point Likert-scale that ranges from (1) never, (2) rarely, (3) sometimes, (4) usually, and (5) always. Therefore, the higher the scores, the better the reported levels of wellbeing in each domain. White et al. (2014), Gaines (2014), and White and Ramirez (2015) reported that the scale shows satisfactory reliability in terms of internal consistency and good construct validity for the contexts of India and Zambia.

*Subjective Well-being (SWB)*

Two of the most used global indicators of SWB were employed in the current study: happiness and life satisfaction. The happiness question reads as follows, “In general, how happy would you say you are?” The life satisfaction question asked, “Taking all things together, how satisfied are you with your life as a whole?” To keep a consistent scale throughout the survey, these items were also measured in 5 ordinal levels. The scale was coded as (1) Very unhappy/unsatisfied, (2) Unhappy/Unsatisfied, (3) Neither happy/satisfied nor unhappy/unsatisfied, (4) Happy/Satisfied, and (5) Very happy/satisfied. As is recommended in the literature (International Wellbeing Group 2006, Bradburn 1983), given their general nature, these questions were located earlier in the survey and before the IWB scale, to avoid influencing the participant’s responses with the more substantive questions about their wellbeing posed by the IWB domains. These two items of the SWB approach have been validated in diverse contexts of the world and are now internationally renowned measures to assess people’s emotional and cognitive evaluations of their lives. These measures have also been extensively used in Mexico (see Martinez and Rojas 2012 for a review) and are now formally included in the BIARE questionnaire which was designed by the National Institute of Statistics and Geography in 2012 specifically to measure the SWB of the Mexican population (see BIARE 2012).

*Quality of Relationships with Officers scale (QoR)*

A set of questions designed to measure the quality of the relationships with the health officers were developed from the interviews and focus groups conducted with recipients. As mentioned above, the qualitative study had the specific objective of exploring the recipients' experiences in the local clinic, their perceptions of the quality of their interactions with the staff, their understanding of what could be a good quality of relationship with them, and ultimately the ways in which this relationship affected their wellbeing.

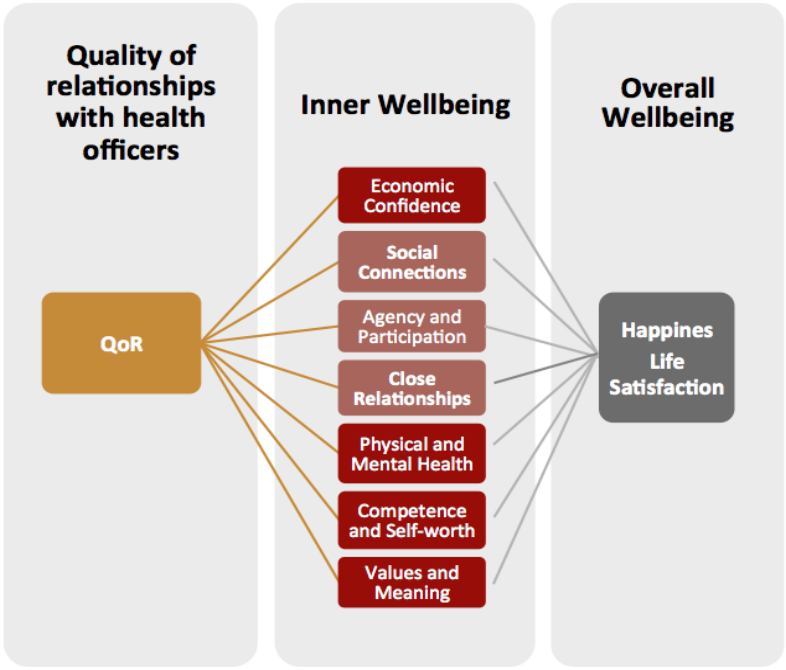
Qualitative analysis revealed seven themes about the quality of this relationship: Good communication, Time issues, Confidentiality, Respect or Humiliation, Dedication or Care, Abuse of Power, and Discrimination (these findings will be explained in detail in chapter five). These themes were the basis used to construct the 14 items of the Quality of Relationships with Officers (QoR) scale. Two examples of these items are: "Do you feel the doctors or nurses treat you with kindness and respect?" "Do you feel that the doctors and nurses are sensitive to you and your needs?" (see table 7.3 for all items). While the main source for constructing the questions was the narratives of recipients themselves, the wording and formatting of the questions was also triangulated with previous surveys evaluating the quality of the relationship with medical staff in other contexts (e.g. Picker Institute Europe n.d., CAHPS 2012, Merkouris et al. 1999, Saha et al. 2003, Steine et al. 2001).

Keeping consistency with the rest of the survey, these items are of ordinal nature and measured in a 5-point Likert-scale, where 1 represents the most negative evaluation of the relationship, (e.g. "I never feel treated with kindness and respect" or "I often feel discriminated against" for reverse coded questions), and 5 the most positive evaluation ("I always feel treated with kindness and respect" or "I never feel discriminated against").

Figure 4.6 presents the core quantitative analysis conducted with the aforementioned instruments. The *left side* of the figure illustrates the goal of understanding the association between the QoR scale and each of the domains of the IWB model. In contrast, the lines that link the domains of the IWB model with the indicators of subjective wellbeing in the right side of the figure indicate that the SWB indicators (happiness and life satisfaction) are used to further examine the relationship between QoR and IWB with the established indicators of subjective wellbeing. It is essential to stress that these lines do not imply causation for two reasons. First, because the

research design of this project is non-experimental and thus cannot isolate the effect of unobserved variables; and secondly, because the complexity of the social phenomena under study impedes measuring their whole makeup and identifying all unobserved variables and causal links. Indeed, causality is very difficult to establish when dealing with multiplex phenomena such as wellbeing and social relationships.

**Figure 4.6** Quantitative Study




*Structure of survey*

The final survey was structured as follows. It commenced with simple and brief section of demographic questions[47] to help set the scene to how the survey needed to be answered (i.e. by simply choosing an option or score from the scale). The second section of the questionnaire scrutinised wellbeing since it was perceived as the most taxing of all. Within this section, the SWB questions were located at the beginning (first the happiness and then the life satisfaction question) to avoid any influence from the IWB domains on people's global wellbeing evaluations. The third section measured the recipient's relationship to *Oportunidades* and to the health officers where the QoR scale was located. The last section was used to collect information about the housing and dwelling conditions of participants in order to construct a proxy of wealth (appendix E).

[47] Age, gender, marital status, religion, and occupation.

#### 4.5.3.2 Pilot study

Before the application of the final version of the survey to the definitive sample, the instruments were translated and tested through a number of piloting procedures. Cualcan was the locality in which the survey was designed and implemented for the first time but also the locality that presented the greatest challenges since most participants spoke Nahuatl (indigenous language) as their mother tongue. Hence, most piloting procedures were conducted in this locality.

##### *Translation*

The translation of the English-version measures of the IWB model into Spanish was supported by an extended discussion with the principal researcher of the Wellbeing Pathways Project (Prof. Sarah C. White) about the initial meanings and intentions of each indicator. In addition, the qualitative study held before the design and application of the survey was indirectly helpful as these tools improved the researcher's understanding of the social world of participants, the language used to describe their experiences (Hennink 2008), and the way wellbeing was narrated. This phase was helpful to reduce the risk of a researcher's bias in the design of an initial draft of the survey.

##### *Piloting 1: Key informants (Cualcan)*

Prior to piloting, the first draft of the survey was examined with two community members of Cualcan fluent in both Nahuatl and Spanish. Their feedback helped raise initial issues regarding the format of the questions, the use of concepts, and translations into Nahuatl.

They were also recruited to assist me during the final application of the survey (this procedure is explained in detail in the following section). Hence, this discussion also served as preliminary training for the assistants on the future application of surveys[48].

[48] In general, it was explained to the assistants that it was strictly necessary to provide a direct translation of each question and to be cautious in not giving their own interpretation when explaining the questions to avoid deviating from their intended meaning (Eremenco et al. 2005). Therefore, agreement on what the question meant was emphasised at this phase.

*Piloting 2: Semi-structured interviews (Cualcan and Nexpan)*

The survey version resulting from Piloting 1 was then tested during two pilot interviews with *Oportunidades* recipients. This procedure involved applying the survey in the form of semi-structured interviews evaluating the way in which participants responded to the measures, how the items were interpreted, and any difficulty understanding the concepts (Barofsky 1996). Ultimately, this phase helped ensure that the language and terms used in the measures were not only localised, but also accessible and appropriate to the target population.

*Piloting 3: Group-administered piloting (Cualcan)*

In Cualcan, the final phase of piloting involved a group-administered application of the resultant modified version of the survey to 10 recipients. The rationale for this phase was that the final application of the survey would be preferably self-administered. Hence, given the varied literacy levels and language preferences of the population (Cualcan), this phase was needed to test this form of survey application and to further validate the measures by exploring any doubts and reactions from the participants (Camfield 2016). The group was representative of the larger population and all were offered the choice of responding to the questionnaire in three formats, as self-administered in Spanish, or as an in-person interview in Spanish or in Nahuatl.

In this pilot, eight of the 10 participants chose responding to the questionnaire on their own, revealing that indeed the survey could be designed in Spanish and be self-administered. More importantly, however, this procedure showed ways in which the researcher and the assistants could accommodate the needs of those few who would require assistance either because of low literacy levels or little knowledge of Spanish. Even at the expense of the potential limitations of applying the questionnaire in different formats (e.g. interviewer's bias and the varied reactions to the survey depending on the format), this procedure was essential to accommodate the needs of all participants regardless of their personal characteristics. This was also the most feasible procedure given the time and resource constraints of this project.

These four piloting phases proved to be crucial for designing and adapting the final survey to the research contexts. These changes involved adjusting the structure of the questions so they were adequate for Mexican Spanish rather than English, confirming that key concepts within each indicator were meaningful for participants in

both localities, but specially in Cualcan (indigenous locality), and clarifying the extent to which self-administration was possible and the level of support required by participants. Indeed, the inclusion of qualitative methods and a greater engagement with the participants, allowed being mindful of the specific features of the sample, as well as to improve the meaningfulness of the questions for this particular context. Although there are more comprehensive methodological proposals for a contextual approach to wellbeing (e.g. Camfield 2004, 2016), this research project was significantly short in terms of time and human capacity (one researcher) and thus this alternative approach could be considered a middle ground between an extensive qualitative procedure and the uncritical application of quantitative measures.

In Nexpan, only the Piloting 2 procedure was conducted after all piloting procedures in Cualcan took place. The two interviewees expressed being comfortable with the questions and thus the final surveys applied in both localities were equivalent.

#### 4.5.3.3 Participants and sampling procedure

The final survey was completed by three hundred and twelve (n = 312) participants, 142 in Cualcan and 170 in Nexpan. An opportunity or convenience[49] sampling procedure was used given that the surveys were applied during the monthly health workshops delivered at the local clinics. This procedure was chosen since it granted access to large numbers of recipients in a single time and place, and with the space (seats) for everyone to respond the survey comfortably. Conducting the surveys during a time that recipients already had reserved for *Oportunidades* was also beneficial since it minimised the hazards incurred by recipients in terms of time and costs (e.g. of not working).

There are, however, two disadvantages of this sampling procedure. Firstly, since this is not a probabilistic technique is not certain that a representative sample was obtained, reducing the possibility of generalizing the findings to other populations. Secondly, applying in the clinics a survey that asked sensitive questions about the officer-recipient relationship could produce a bias in the recipients' answers for fear of officers getting hold of their responses and identities.

[49] This type of sampling procedure is defined as "one that is simply available to the researcher by virtue of its accessibility" (Bryman 2008).

The latter disadvantage was minimized to the extent possible in two ways. Firstly, in both localities the surveys were held on days in which most health officers were not present either because they were performing administrative duties outside the clinic (Nexpan) or because it was election time and the programme avoids having contact with recipients to reduce the possibility of clientelistic practices [50] (Cualcan). Nonetheless, the recipients were required to travel to the clinic to sign their attendance record although the workshops were not going to be delivered. Secondly, to avoid any feelings of coercion the participants were reassured orally and in written format about the confidentiality and anonymity of their responses and their right to withdrawal at any time. The surveys never asked for personal information that could identify the respondent.

## 4.6 Ethical considerations

Ethical approval covering issues like voluntary participation, consent, anonymity and protecting people from harm, was sought from the University of Bath's Departmental Ethics Committee and approval was granted in November 2012 (appendix F). However, in the fieldwork process a few specific issues arose given the nature of the research study, the policy context in which it was conducted and the wider social context of Mexico.

The context of discrimination and inequality in Mexico sets people apart in terms of gender, ethnicity, skin colour and location (rural, urban). This translates into certain groups experiencing overlapping exclusion and marginalization (e.g. female, impoverished, darker skin, indigenous, rural) and others used to certain privileges (e.g. male, white skinned, middle and upper classes, urban). This context puts the main research participants (the recipients of the programme who are often indigenous and always impoverished) in a recurrent disadvantageous situation compared to health officers and to me as a researcher. Therefore, it was fundamental that the research process did not contribute in any way to this situation. This required me, first, to be mindful about my role as a researcher and about the relationships I built with each participant during the course of the study.

[50] The directors of the clinic and their supervisors granted me permission to apply the survey during those sessions.

Despite being born and raised in Mexico, recipients frequently identified me as an outsider for being white, educated and middle class. This entailed a stronger effort to gain their trust by spending time with them and explaining carefully my role and the goals of the research. I always sought an interaction that promoted respect, reassurance, and an awareness of issues of power in my role as a researcher, but also of cultural and sensitive issues that could situate my participants in an uncomfortable position.

In various occasions during the interviews and focus groups the recipients were wary of discussing themes related to the clinic or the health officers since they were afraid of possible repercussions such as being expelled from the programme (primarily - if not only - in Nexpan). Hence, particular attention was paid in making clear that neither this research project nor the researcher was linked in any way with *Oportunidades*, the policy implementers of *Oportunidades* (*promotores*), the health officers, or the local clinics. This was important to make participants feel free to express their opinions and perspectives about their relationship with the health officers. In addition, the participants were explained that the anonymity of their identities and personal information would be respected during the whole research process. To ensure that this promise was kept, the information gathered was safely kept only by the researcher and the data was coded using pseudonyms to ensure that neither the participants nor the localities can be identified.

My perceived identity had different effects on health officers. Initially in Nexpan, the head of the clinic perceived me as a threat, placing some barriers for me to work on the clinic such as asking for a series of personal documentation like forms of ID, proof of address, and academic credentials. In our first meeting, she displayed aggression towards me by diminishing and mocking my work in front of and with her subordinates, and showing her overarching authority in the clinic. After a few weeks in which I showed that I posed no threat to the health officers, the head of the clinic started interacting with me differently and by the point in which I interviewed her, she talked to me as if I understood and shared her opinions about the recipients (although I never encouraged this). In Cualcan, the head of the clinic viewed my presence more positively, probably because she considered us to share a similar identity (young, white, middle-class, educated women) but also because of our interest in education and research. Her support, respect and conscious detachment for the research facilitated the process.

## 4.7 Conclusion

This chapter has provided an overview of the methodology adopted in this dissertation. Given the research questions and the discussions about the two core concepts of this study (wellbeing and relationships) and the *Oportunidades-Prospera* programme in chapters two and three, this chapter commenced by presenting a case for mixing methodologies and taking a critical realist stance. This allows for the study of the role of officer-recipient relationships in wellbeing from a quantitative and qualitative perspective while taking a more interpretivist approach to subjective wellbeing and being reflective about how the methods influence the findings obtained. The chapter then justified the endorsement of IWB as the wellbeing approach for this study primarily for offering a multidimensional model with a more social lens and for being established in and for developing contexts such as this dissertation's fieldwork settings. Finally, the chapter outlined the qualitative and quantitative strategies undertaken, their purposes, the fieldwork process and some ethical considerations.

The next two chapters present the empirical findings of the qualitative and quantitative studies respectively. Chapters five and six describe the findings from the qualitative study on the characteristics of the officer-recipient relationship from the perspectives of front-line officers and recipients, and their effect on different aspects of wellbeing according to the narratives and experiences of recipients. Chapter seven introduces the core quantitative measures of QoR and IWB, the procedures conducted to construct each scale and test for their robustness. Chapter eight moves on to the core quantitative analysis responding to the questions about the general patterns in the quality of officer-recipient relationship and their statistical relationship with the domains of the IWB model.

# 5. Officer-recipient relationships from the perspective of health officers

## 5.1 Introduction

As explained in chapter three, the procedures of implementation of the health conditionalities of *Oportunidades-Prospera* generate a constant interaction between the clinic's front-line officers and the policy participants. This continual interaction can build a relationship between them; a relationship that this dissertation hypothesises to be potentially vital for the success of the programme's aims and for the ability of *Oportunidades-Prospera* to improve the wellbeing of its participant families.

To begin to understand the effects of officer-recipient relationships on wellbeing, the aim of this chapter is to describe the relationship using the narratives and experiences of health officers. In line with a critical realist approach, people make sense of the world and create meaning not as atomistic individuals but through social interaction. Hence, to better understand the nature of the relationship between officers and recipients in the context of *Oportunidades*, it was deemed valuable to understand this relationship from the perspectives of both actors involved.

To achieve this I conducted a thorough discourse analysis of the interviews with seven female health officers in the local clinics of the communities of Nexpan and Cualcan. During the analysis I concentrated on the way in which officers talked about the recipient families, their relationship with them, and their roles in the implementation of *Oportunidades* and in the clinic (both the recipients' and theirs). The findings from these interviews are presented in conjunction with the data obtained during the period of observation. The quotations used were provided by the officers participating in the study who are identified by an alias. The quotations are classified in an alphanumerical code to retain the sequence in which they are presented (e.g. O1 symbolises 'Officer's quote number 1'). These are the main findings.

## 5.2 The Frame of the Relationship

The narratives of the front-line officers in both local health centres uncovered two structures that work as scaffold to the kind of relationship continually formed between the recipient families and the officers, and that provided a context in which this relationship unfolded. The first and more direct frame is associated with the identities of the two actors involved in the interaction, the recipient and the officer. This also involves the way in which officers interpret their identities and how these influence

their attitudes towards the other. The second frame is associated with the language of conditionality embedded in *Oportunidades*. As is shown below, this language shaped the terms and conditions in which the interaction developed and the officers' assumptions of their own roles and those of recipients. These structures are called the frame of the relationship since they do not constitute direct behaviours from the actors during their interactions but certainly influence how these interactions take place. These frames are present throughout the quotes and the analysis, and as such, they deserve special attention.

### 5.2.1 *Oportunidades-Prospera's* discourse of conditionality

The *Oportunidades-Prospera* programme is in direct contact with the recipient families mainly outside the health centres during the provision of the cash transfers and sporadic meetings with the *promotor*[51]. Through the conditionalities, however, the programme dictates the (minimum) frequency and the terms in which the officer-recipient interaction takes place inside the local clinic. Thus, it was this discourse of *conditionality* which constantly framed how the health officers talked about the implementation process, the recipients and their roles within the clinic.

> *We call it 'captive population' in the sense that it is compulsory. We have to schedule their medical appointments and if they do not comply they get an absence [in their attendance record]. If they do not want to get an absence, then [they have to comply].* Maria, Permanent Doctor, Nexpan (O1)

As mentioned in chapter three, the health officers regulate the conditionalities of the programme through an attendance record. Therefore, when recipients did not comply with an activity they got an absence on it. However, rather than considering the services provided as an entitlement of recipients, the officer's constant use of concepts like *compulsory* in the previous quote, as well as obligation, compliance and obedience when describing the conditionalities were frequent.

[51] The *promotor* is a front-line officer directly hired by *Oportunidades-Prospera* to coordinate the institutions that deliver the programme (schools and local clinics), supervise the delivery of the cash transfer, and to be the direct link between recipients and the programme by, for example, organising and training the *vocales* and the recipients. The relationship between the *promotor* and the recipients constitutes another relationship that would be interesting to study.

*They do come and comply. Occasionally some do not comply, but they end up doing it because they want to remain in Oportunidades.* Clara, Permanent Dentist, Nexpan (O2)

Based on the health officer's accounts, much of their interactions with recipients were determined by a perception of the recipient as the one who has to comply and the officer as the one who regulates, enforces and mediates the conditionalities and services offered by *Oportunidades*.

*A lot of people do not come because "oh, I forgot", or because "I was lazy to come early so I didn't". Obviously if they come with a sick note or proof that something urgent happened, you (officer) decide if you justify their absence or not. Because as they receive the [cash transfer], they also acquire an obligation.* Diana, Temporary Doctor, Nexpan (O3)

*We tell them how they have to participate, that they always have to come to their health check-ups, what documents they have to bring. And with the aim of getting them to attend, I tell them that whoever does not come to their consultations or their vaccinations, they get an absence from Oportunidades. Because this is the only way they come and the way we have been handling it so they comply.* Andrea, Temporary Nurse, Cualcan (O4)

As these quotes show, the *Oportunidades'* discourse of conditionality infiltrates the terms of the relationship through the strategies officers use to promote participation, their expectations from recipients, and their understanding of their own roles in the delivery of the programme. Together these create what could be considered a disciplinary relationship in which the attendance record is an authoritative tool officers can use at their discretion for reminding recipients that if they wish to remain in the programme their participation is compulsory.

### 5.2.2 Identity

The accounts of officers also suggested that their own identities and their reading of the identities of recipients were central frames of their interactions. From a panoramic outlook of the narratives of health officers, interactions with recipients were shaped not only by their status as *Oportunidades'* officers, but by their identity as a particular kind of officer, physicians or nurses. The officers understood this institutional relationship mainly as one between medical staff and patients. In both localities,

*Oportunidades* recipients are a large group of the population (in Cualcan it is half of the total population) and unquestionably the group that uses the clinic the most. In spite of this, the officers talked about them far more frequently as patients than as recipients of the programme.

> *The programme is applied at the national level and is implemented [*in the clinic] *through the health ministry. What happens is that the pa… no, not patients, they are called… the beneficiaries register to the programme (…) and when they are accepted they come here so we can generate their annual schedule of medical appointments*. Diana, Temporary Doctor, Nexpan (O5)

Indeed, in the day-to-day practice, the line between a recipient and a patient was incredibly blurry. In contrast, officers clearly labelled themselves as doctors or nurses rather than as front-line officers of *Oportunidades*. Even when describing their roles in the delivery of the programme, they never spoke of themselves as officers. This is probably because, as the following quote suggests, *Oportunidades* is only part of the work they do in the clinic; but also because they are not the direct employees of the programme.

> (Researcher: What is your main role in the clinic?) *I am the director of the clinic. I am a doctor.* (Researcher: And what does that imply?) *Oh! Well, everything (laughs). Starting from giving medical consultations. We are doctors but we focus on prevention. So, the greater number of healthy consultations we have, the more impact our service is having. We cover at least 15 programmes, Oportunidades is among them*. Maria, Permanent Doctor, Nexpan (O6)

As is evident throughout the analysis, the identities of doctors and patients is probably the most important frame of the terms of the relationship between the recipients and the officers that enforce the health conditionalities of *Oportunidades*. The identity of recipients as poor or indigenous people was only explicitly mentioned once or twice during my conversations with the officers.

> *Oportunidades is given to families that have greater economic needs. The programme includes that you have to check them every 6 months, they have to come in for a medical consultation, and us in the dental area take advantage of this because they would never come for dental consultation on their own will. (Researcher: Why do you think so?) Well, because even though Nexpan is close to a city, I feel that is a region that… since they are farmers, they don't have the… how can I put it? They do not value their dental health. They do not*

*have the knowledge or the education. They are a little bit backwards in that regard.* Clara, Permanent Dentist, Nexpan (O7)

*Imagine how she* (Maria the director of the clinic) *would talk about a person who… I mean, a lot of the beneficiaries cannot read or write. So the treatment is not good, no.* Diana, Temporary Doctor, Nexpan (O8)

These quotes come from different contexts in the conversations. Both of them, however, show a differentiation between officer and recipient based on identity. In this case identifying the 'beneficiary' as poor, uneducated, and a farmer. A differentiation that, as shown in quote O8, can lead to discriminatory treatment. In Cualcan, the indigenous community, there was only one mention of this but with a rather different tone.

*We need to make sure that [recipients] understand. Sometimes it is difficult to communicate because some people do not speak Spanish well. And we should not get annoyed about this, 'oh no, she cannot speak Spanish'. We also need to understand them so we can explain things better*. Andrea, Temporary Nurse, Cualcan (O9)

In this quote the nurse is acknowledging the identity of recipients as indigenous and the challenges of the language barrier during the delivery of the programme. She nonetheless goes further, reflecting on her own role in being understanding and in making sure that she is effectively communicating with the indigenous recipients.

As it is noticeable from these quotes, there is a negative tone about this differentiation based on identity particularly from the permanent officers and particularly in Nexpan. Whereas this is discussed more profoundly in the following sections, this contrast in the officers' attitudes towards the recipient families was in fact present in all the themes that emerged during the analysis.

### 5.2.3 Temporary versus Permanent Officer

Despite the complexity of the job positions established by the National Health Ministry in Mexico, in these two communities there was a clear difference between the narratives of officers based on their employment status within the clinic. As it has been mentioned, I conducted seven interviews with health officers in both localities (two in Cualcan and four in Nexpan). Yet, the interviews could also be categorised in

terms of the officers' employment status as permanent or contract-based (3), and as temporary or student-based (3).

In the case of Cualcan, the two officers interviewed were students (one physician and one nurse) working in the locality for a year as part of their final year training before graduation[52]. In some countries this is also called an internship and therefore is an "unpaid" service they provide to the community. The medical intern in Cualcan was the current director of the clinic since there was no permanent doctor at the time. In Nexpan, only one of the four officers interviewed was a medical student or intern and the remaining three were certified clinicians (one doctor and the director of the clinic for the last three years, one dentist and one nurse) who were paid for their services.

As the rest of the chapter shows, in the interviews there was a consistent and clear distinction in the way officers described their relationship with recipients depending on their position within the clinic. The temporary officers corroborated this by describing in a similar way the attitudes that previous or current permanent officers had towards the recipients. Here are two examples of this acknowledgement.

> *A previous nurse trained me and I also observed her and learned how she treated people. So I got an idea of how to work. But there were some things that I changed because sometimes people said she had a very bad temper so I tried to be kinder to people because some said, "I rather not go (to the clinic)". Others said that the [*former permanent doctor] *was constantly scolding them, so they didn't want to come to their consultations. So I try to be better*. Andrea, Temporary Nurse, Cualcan (O10)

> *There are some staff who, since they already hold a position and they get paid, they take advantage of the power that this gives them.* (Researcher: And do you feel that this happens in this clinic?) (Laughs) *Yes, yes it happens.* Diana, Temporary Doctor, Nexpan (O11)

These accounts problematize the exercise of power and abuse from permanent officers. They also depict temporary officers consciously taking a different approach towards their relationship with recipients. These contrasting attitudes and type of relationships created by temporary and permanent officers were present in all the themes that emerged from the interviews. Hence, while the presentation of the main findings maintains a comparison between localities, the difference between

[52] It is important to mention that in Cualcan I tried to interview the only permanent officer in the clinic at the time (a nurse) but she refused to be interviewed.

temporary and permanent officials compose the main structure of this section. The possible reasons behind these differences between permanent and temporary officers are discussed in section 5.5.

## 5.3 The characteristics of officer-recipient relationships in the narratives of health officers

The chief objective of interviewing the health officers was to understand their perspectives about their relationship with recipients. During the interviews this was explored in two ways. Firstly, by asking officers directly to describe their relationship to recipients. Secondly, the stories they used to explain the process of policy delivery, their challenges during this process, and their overall experiences in their job and the localities offered an indirect account of the relationship. These interviews provided an insight into the way officers talked about the localities, the recipients, and themselves, as well as insight into their assumptions, attitudes, and use of language. This section sheds light to the terms and conditions in which the interactions between recipients and officers unfold in these two localities.

Overall, the narratives of officers showed that these localities by and large witnessed two contrasting officer-recipient relationships. In Nexpan, the relationship with the permanent officers was hierarchical, mostly characterised as one of obedience, power and disengagement. In Cualcan, in turn, the relationship with the temporary officers was more horizontal, and could be described as one of reciprocity, communication and empathy. The following section tries to justify these quite striking differences using the words of officers.

### 5.3.1 A relationship of obedience and hierarchies: Permanent officers

In response to the question, “how would you describe your relationship with the recipients”, the permanent officers in Nexpan started by describing a rather positive relationship and denying any conflict with recipients. However, the tones and words used suggest a rather ambivalent relationship that easily moved from the positive to the negative.

> *Good, you have to have a good [relationship] because if you don’t they don’t obey you. There needs to be empathy and respect, but also authority because*

*they are a lot [of recipients] and all behave like children, "I arrived first, why her and not me?" (Imitating a 'recipient' with a childish tone) And they are only looking [what to complain about]. So you have to treat them all at the same level*. Maria, Permanent Doctor, Nexpan (O12)

*Apparently [the relationship] is calm and normal (laughs sarcastically). There is the one who gets upset because there is no consultation or whatever, but you try not to be affected by it (laughs) because there are some [recipients] who are insolent* (she conjugated the word in Spanish in a way that is usually used in a degrading manner or with a superiority tone: 'groseronas'). Ana, Permanent Dentist, Nexpan (O13)

These quotes provide numerous insights into the character of the relationship between the recipients and the permanent officers during the time of the fieldwork. The beginning of quote O12 suggests an expectation from the officer that recipients should behave obediently. It also points out to a conception that an authoritarian relationship was necessary to maintain control of recipients. Strikingly, for a permanent officer, the most important purpose of having a 'good' relationship with recipients was the benefit she obtained from their participation.

*I do not harass them or mistreat them, I cannot do so because if I do they will stop wanting to comply, you understand?* Maria, Permanent Doctor, Nexpan (O14)

An important part of the officers' job was to achieve certain monthly quotas in the health programmes set by the Health Ministry, programmes that in many cases were external to *Oportunidades*. If this was not achieved, the clinic received some type of penalty. Therefore, it could be said that recipients were instrumental for officers in pursuing this duty.

*I rely a lot on Oportunidades. We call it captive population in the sense that it is compulsory. We have to give them appointments [and] it is there where we apply all our programmes, we examine them based on all our programmes. Yes, we combine all the programmes that we have and in that way I have productivity in my own programmes and we have Oportunidades completely covered*. Maria, Permanent Doctor, Nexpan (O15)

Indeed, thanks to the recipients' condition as "captive population", officers were able to satisfy their quotas. This takes me back to the way in which the language of

conditionality implemented by *Oportunidades* is used to frame the officer-recipient relationship.

Returning to the initial quotes of this section, the response of Ana in quote O13 reinforces the existence of a hierarchical relationship in the offensive tone in which she talks about recipients ("there are some who are insolent"). This tone also suggests a kind of disengagement from the recipients and their needs. Indeed, frequently a sarcastic tone was used when talking about recipients.

> (Researcher: In general what have you liked about working in this clinic and in this town?) *Well… I have liked that they do obey as long as you explain things to them and talk to them right, because they don't like that (long laugh)… We need to treat them well.* Maria, Permanent Doctor, Nexpan (O16)

> *[About working] in the town? (laughs) The town… the town… Who knows (laughs sarcastically), I don't know the town (laughs)… Well… I don't really leave the clinic, but one works with the people… There are people who are grateful and others that are rude, we have of all types. There are people who do understand you, but they are very few.* Ana, Permanent Dentist, Nexpan (O17)

The officer in quote O17 starts with denying any relationship with the town but then seems to reassess this by acknowledging that she has daily contact with its population during the dental consultation as well as when she helps with the *Oportunidades* procedures. Then, instead of talking about her experience she continues to label recipients in a particular way, for example as either grateful or rude. This was not necessarily the particular personality of one officer. Rather, in most of the accounts of current or previous permanent officers, there was a constant disengagement from recipients. There was a differentiation between 'us and them' and a need to make clear this difference through tones of superiority and degrading characterisations of recipients.

> *People here are quite close-minded. Well, (long pause) it is not that they do not have the knowledge, what they don't have is the willingness to learn. (…) People do not have much education because even though you explain things to them they do not understand. I think it requires a lot of effort from them, because of their customs and [because of] what one is telling them.* Clara, Permanent Nurse, Nexpan (O18)

This negative way of characterising recipients in Nexpan and by permanent officers (as backward, unwilling to learn, and uneducated) was recognised by the only temporary doctor in the locality in the way the director of the clinic talked about and to recipients.

> *There are some staff who, since they already hold a position and they get paid, they take advantage of the power that this gives them.* (Researcher: And do you feel that this happens in this clinic?) *(Laughs) Yes, yes it happens. But you will see it yourself. I could tell you things but don't tape them* (laughs) *(…) The doctor (Maria) discriminates [recipients] a lot*. Diana, Temporary Doctor, Nexpan (O19)

And indeed, in her interview, Maria confirmed this attitude.

> *I don't like to antagonise with the people, why? Because if I do they stop obeying you and the tables will turn around! They are aggressive, they all gang up, they are liars, because even though it is not true, they say you mistreated them or that you didn't want to give them consultations or they say… um… that you talked to them badly. I mean, they start talking about mistreatment, wrongful charges, or things like that. (…) So you think I will be risking being bad to people seeing how they are?* Maria, Permanent Doctor, Nexpan. (O20)

This passage reinforces the relationship of power and authority that was created in Nexpan, especially by permanent officers. Yet, it also speaks about the ambivalence of power and its uncertainty. The officer also feels she has to comply with 'being nice' to recipients. Additionally, the quote also supports the common negative characterisation of recipients as rude or lazy for example (see also O12, O13, O17, O18, and O20). Finally, it describes (as in O12 and O13) a tendency of redirecting the focus towards the recipients as sources of any conflict that emerged in their relationship.

It is important to highlight again that this type of relationship between recipients and permanent officers was also salient in my observations of the only permanent officer in the clinic in Cualcan (Elena, a nurse). Despite not being able to interview her (she refused), my observations during the workshops suggested that she addressed the groups in a rude and authoritarian manner. Elena did not show openness towards recipients and the recipients reacted by approaching another officer with questions and avoiding her.

In sum, the relationship between permanent officers and recipients could be characterised as one of hierarchies, power and obedience. In many ways officers tried to exert their power over recipients, it was rare when they showed empathy towards them and their situation, and they sometimes talked about recipients in derogative tones. Officers were also aware of the potential collective power of recipients but this was referred to in a negative way and even as a threat. Similarly, recipients were often depicted negatively, conferring to them and their attitudes the responsibility of a good relationship. Finally, officers did not reflect on their own role in the quality of the relationship, and instead offered the aforementioned contradictory attitudes that quickly shifted from the positive to the negative.

### 5.3.2 A relationship of empathy and reciprocity: Temporary Officers

The tone in the interviews with the temporary officers in Cualcan was unlike that from permanent officers in Nexpan[53]. In their narratives and attitudes, officers from Cualcan described what could be considered a more horizontal or egalitarian interaction. The following excerpts are their direct responses to the request of describing their relationship with recipients.

> *[The relationship] is very good because, they participate in anything we ask them to. This is because we try to talk to them kindly. They do participate. Some just can't, and others are a bit (laughs) rebellious and don't like to [participate], but they are a minority. But yes, I have liked a lot that everyone participates, they are united and when they get organised they do it well. With Elena* (permanent nurse) *they do not have a good relationship because her treatment is very surly, very aggressive (…) but with me, they participate well and support me if we need anything in the clinic. They come and ask "do you need anything doctor?"* Lorena, Temporary Doctor, Cualcan (O21)

> *Now there is a good relationship. If any [problem] escalates we talk to them, have a conversation with them. For example, if the number of consultations given now is less than what was given before, we let them know so that they understand the situation and the reasons why there are less consultations. We try to communicate with them.* Andrea, Temporary Nurse, Cualcan. (O22)

[53] The accounts from the temporary officer in Nexpan resonates more strongly to those of the temporary officers in Cualcan.

These storylines have rich information about the approach temporary officers in Cualcan took towards recipients and towards their roles in the relationship. On the one hand, O21 shows a positive tone while describing recipients as participative and supportive to the clinic. On the other hand - and in contrast to the approach of permanent officers - both quotes suggest a reflection about their own role in constructing a positive relationship by emphasising communication (O22) and good treatment (O21, and also O20). Indeed, these officers constantly considered the effects they could have on the recipients' feelings and on their attitudes towards the programme. There was an interest in providing better treatment not for their own benefit but with the purpose of improving the recipients' participation and attendance to the consultations. In the next quote, Lorena goes further by recognising on how her attitude towards recipients affects the confidence and emotional wellbeing of recipients.

> *I feel that [recipients], at least unlike the previous doctor, have a little more confidence to approach me. They are not afraid anymore, they do not get angry, they do not think that they will come only to get into a fight or get reprimanded. So yes, is nice that the people themselves say they receive a better attention.* Lorena, Temporary Doctor, Cualcan (O23).

Temporary officers coupled quality of medical attention with quality of relationship in many instances. For them, a relationship of quality with recipients was especially one of communication (see also O21 and O22). This awareness was constantly present in the interviews with officers and in the observations. The empathy from temporary officers that is illustrated in O23, was also translated to the strategies used to enforce the conditionalities of the programme.

> *During the pet vaccination campaign (…) I have photos of 'señoras' (ladies) holding their dogs, with their cats inside bags (laughs). I got to vaccinate dogs, fleas bit me, a dog bit me. They (recipients) laughed at me, made fun of me… well. But that is the good part, isn't it? It is nice to develop a relationship [with recipients] and with the kids as well. So the environment is nice and everything comes together: you spend time with the people, they bring their pets for vaccination, and they comply with their workshop of Oportunidades. You kill two birds with one stone. That is why Oportunidades is useful because [recipients] are interested in the signature to have their attendance record full since it leads the support that they receive (the cash transfer)*. Lorena, Temporary Doctor, Cualcan (O24)

*Sometimes I deliver the workshop and what you do is converse with them in a way they understand what I am telling them. And I also help organise the chores [of the health committee] and what I have liked is that I team up with [recipients] so that there can be a good result [in the work]. Because if I only go and tell them 'do this and do that' and I come back in to do my own work, well, they are going to say 'she only comes to command and not even helps'.* Andrea, Temporary Nurse, Cualcan (O25)

As the first quote (O24) shows, Lorena the current clinic chief, is not only focusing on her own advantage in applying her quotas of vaccinations thanks to the condition of recipients as a 'captive population'. She also recognises the value of these events in developing a positive environment around the clinic and the profit recipients obtain from better public health and from gaining one more signature in their *Oportunidades*' attendance record. These excerpts also depict the narratives of a more equal and reciprocal relationship in which officers and recipients share the responsibility of the chores within the clinic. These accounts of the process of implementation of *Oportunidades* reinforce the description of this relationship not as one in which power is absent but one in which officers use their power in a different way. They use it not to force obedience, but to promote a participation that benefits both recipients and them.

However, the fact that the officers' accounts suggest that hierarchies did not rule the relationship does not mean that there were not conflicts or an exercise of authority from officers. The officers did acknowledge the existence of conflict, as the beginning of O21 shows. Yet, instead of identifying who was the guilty party in the conflict they focused on the causes and their attempts to solve the conflict. As O22 shows, in most cases the temporary officers in Cualcan used communication as a tool to resolve conflict with recipients. However, in some of their accounts the word reprimand was employed in a particularly interesting way. This can be illustrated by the following quote where the officer is expressing her bewilderment about why some recipients are more interested in the cash transfer than in their health. She gives the example of a recipient who constantly comes to the clinic for duties related to the programme. Still, for months she did not get her blood sugar checked out, resulting in dangerous levels of glucose in her blood.

*I talked to her about this, I don't know, I reprimanded her. No, I lectured her so she can reflect on this. I explained the consequences this might bring [to her health]. (…) The kind of situation that I like to create is that if they are not*

> *complying (with Oportunidades), I try to give them orientation. To tell them in a way that, it is not a nice way because we are talking about a situation in which you cannot play around. It is a situation in which their health is at risk and they have to be aware that they need to be regularly checked out. So, I reprimand them in a direct way but without being disrespectful. Without yelling, scolding, humiliating, without any of that. Instead, creating awareness about the importance of taking care of themselves.* Lorena, Temporary Doctor, Cualcan (O26).

In this community and in general, the temporary officers did mention what can be considered the hierarchical concept of 'reprimand' (as in a parent-child relationship). Nonetheless, in the way they used it, the ultimate benefit was for the recipient and not their need to maintain a disproportionate level of authority. In this case, it was about the risks to the recipient's health because of her lack of compliance. In other cases, the officers in Cualcan and the temporary officer in Nexpan, used the word reprimand to make recipients aware that they were about to lose the programme for not complying. Finally, often when talking about reprimand, the temporary officers showed awareness that even though they considered it necessary, it was always done in a respectful way.

Overall, the tone of the officers in Cualcan and of temporary officers in general was of empathy and engagement. Their strategies of implementing the programme were more reciprocal and less hierarchical, and during which the perspectives and feelings of recipients were taken into account. The authority of officers in this context was not enforced through power or discrimination, but through trust, communication, and respect. Indeed, there was a striking difference between the attitudes of permanent officers and those of temporary officers, resulting in important disparities in the terms of their relationship with recipients. In the following section, these contrasts are explored in more depth by analysing two topics, the officers' outlooks on their roles in the clinic (and thus of the recipients' roles) and their narratives of the recipients in general.

## 5.4 Contrasts between permanent and temporary officers: Key themes

### 5.4.1 Narratives of the roles of officers and recipients in the implementation of *Oportunidades*

In the interviews officers were asked about the strengths and challenges of the clinic during the implementation of the programme to try to understand how they perceived their own roles and those of recipients in it. When discussing the strengths, all officers concentrated on their own roles and activities such as their effective organisation and how they follow procedures. Their motivations or aims for doing so were, however, rather different. The permanent officers in Nexpan considered that their organisation allowed them to apply all the health programmes that the clinic was expected to by the Health Ministry (see O15). Therefore they mostly saw the advantages they were obtaining from the condition of the recipients as 'captive population'. In contrast, albeit that the temporary officers in Cualcan also focused on their own capacity to follow procedures efficiently, their motivation for doing so was achieving a greater participation from recipients for their own good of remaining in the programme.

> (Researcher: What are the strengths of the clinic in the implementation of *Oportunidades*?) *What we do well is encouraging people's participation, because if they stop participating in what they are expected to, they lose the [cash transfer].* Andrea, Temporary Nurse, Cualcan (O27)

When discussing the clinic's challenges in implementing *Oportunidades*, temporary and permanent officers raised three themes. Firstly, only temporary officers reflected on the need to improve their organisation in terms of consultations and paperwork as well as better communication among staff. The permanent officers concentrated on other actors like the external institutions involved in the clinic's performance. For them, the constant failure of the National Health Ministry and the local government to provide the necessary resources and staff, limited the effective functioning of the clinic (this is discussed in more depth further on). Finally, both temporary and permanent officers considered the recipients' participation central to the effective delivery of the programme.

> (Researcher: What difficulties the clinic faces in the implementation of the programme?) *Well that [recipients] support us. [The difficulty] is that people do not want to support us or comply. There are certain rules, [for example], that they have to arrive at a certain time. But [although] they know, they arrive later.*

*(…) They have rights but also duties and rules, don't they? But often the people does not educate themselves to arrive at a certain time, sometimes they want to come whenever they... But we* (officers) *not only have to attend to them, we have to do other activities!* Ana, Permanent Dentist, Nexpan (O28)

### 5.4.2 The good and the bad recipient

In the interviews, it was salient the assumptions officers had about what was considered a positive attitude from recipients and those that were frowned upon or conflictual. In many situations both temporary and permanent staff described the recipients as demanding or dissenting. Yet, the contexts in which these words were used and how they were interpreted also reflects the contrasting hierarchical and egalitarian relationships built by the two kinds of officers.

*[Vocales] are more demanding. They think of themselves as having more rights. Some more than others are kind of picky.* Ana, Permanent Dentist, Nexpan (O29)

*Some (recipients) have an aggressive attitude, they are dissenters!* Maria, Permanent Doctor, Nexpan (O30)

As these quotes show, for permanent doctors in Nexpan, people demanding their rights or defending their position was interpreted as being aggressive or dissenters. It was definitely an attitude that was not well regarded by officers and even considered a threat (see O20). In contrast, a good recipient was one who was docile and obedient (see also O16, O17).

*As long as the people are calm when they talk to you, well, then you stay calm too. I mean, that they let you do your work.* Ana, Permanent Dentist, Nexpan (O31)

In Cualcan, being demanding was narrated as an entitlement but also as a sign of previous mistreatment from doctors. While it was not narrated as a negative attitude, they did consider it a challenge in their own relationship with recipients.

*In general the community is good, but difficult if you don't know how to work with them. If you don't know how to comply with their needs because they will always be demanding. They are no longer the people who did not react, who were repressed*. (Researcher: Why do you think they changed?) *In terms of the*

> *clinic and the fact that they demand their rights, [they changed] because they did not like the mistreatment from other doctors (…) I mean, before the people was more peaceful. Now they treat you the way they get treated by you*. Lorena, Temporary Doctor, Cualcan (O32)

Although for the temporary officers in Cualcan recipients were entitled to fight for their rights, this defensiveness made their interactions more complex even though it was developed as a result of historical mistreatment. As a result, officers needed to treat recipients and take decisions in a way that was transparent and considerate.

> *There are some people who are sensitive so we need to be aware of not offending them because they do not like that at all*. Andrea, Temporary Nurse, Cualcan (O33)

> *Everything is done in a way that everyone knows and everyone agrees, because if you don't, they think that we imposing things and they don't like that at all*. Lorena, Permanent Doctor, Cualcan (O34)

In sum, in the case of the permanent officers in Nexpan, there was what could be considered an idea of the good and bad recipient. The good recipient was one who had a docile attitude and followed orders. The bad recipient was one who demanded rights they were not entitled to from the officers' perspectives. Temporary officers did not follow this dichotomious interpretation. They held a positive understanding of recipients as participative, organised, and helpful; and also narrated the demand of their rights as their entitlement. This use of agency, however, was also recognised to be difficult in certain contexts.

This situation, however, provokes the question as to whether the less hierarchical relationship promoted by temporary officers is determined by their nature as temporary doctors or by the characteristics of the recipients they engaged with. In other words, is the fact that recipients in Cualcan are prepared to use their agency to act and provoke change (and that they have used it before) a determinant of the kind of relationship generated with the officers? Based on the data, the response to this question is: both. First, the positive relationship of the temporary officers with recipients was found in both localities, not only Cualcan[54]. Therefore, temporary officers do seem to have a particular approach to recipients and their own work, one

[54] As seen in chapter six, the accounts of recipients in Nexpan suggested that they not only had experienced a positive relationship with the current temporary doctor, but also with former ones. One recipient stated: "we always trust interns more" Cecilia, vocal, Nexpan.

that underlines communication and equality. Similarly, even though I did not interview the only permanent officer from Cualcan, the accounts of the other staff and my own observations suggest that her profile was closer to that of the permanent officers in Nexpan.

Secondly, the attitudes of recipients do seem to influence the terms of the relationship. Indeed, in Cualcan - as is shown in the previous quotes - the community proved to be empowered and prepared to use their agency to provoke change in their environments. Instead, in Nexpan, recipients (as they described themselves in the focus group) felt impotent about the attitude of the officers and frustrated by their lack of organisation to change their situation. These contrasting attitudes from recipients might have an influence on the kind of relationship created between them and the officers. The next chapter concentrates on the recipients' accounts of their relationships and its role in their wellbeing that were explored in focus groups and interviews.

## 5.5 Exploring the reasons behind these opposite relationships

A subject that was left unresolved is why permanent and temporary officers showed such striking differences in their encounters with recipients. It is difficult to have conclusive arguments in this regard due to the nature of the data collected. Still, there are interesting clues that we can explore.

### 5.5.1 Time matters

One of the most evident differences between permanent and temporary officers is the fact that the former work on a contract-basis and receive payment for their services while the latter do not. This difference could have two effects. The first is associated with time. For temporary officers their time in the locality and holding that position is only transitory. Therefore, their encounters with the challenges and routines of the job have not only been brief but this novelty could justify their positive attitude towards it. Permanent officers, on the other hand, have a more constant position and greater responsibility within the clinic, which increases their stress and tiredness towards their

duties[55]. Secondly, the fact that permanent officers worked under a contract could give them greater authority and therefore more power within the clinic (see O11 where Diana the temporary officer of Nexpan admits this for this clinic). This power could be used in different ways by officers. For example, as Diana admits in O11, in Nexpan this power translated into bad treatment for recipients and a clear hierarchical relationship.

### 5.5.2 The Health Ministry

The role of the Health Ministry in the operation of the clinic could also have a direct influence on the attitudes of officers towards their work. The Health Ministry regulates all the procedures of the clinic, the rotation of staff, and the provision of medical instruments and medicines. In both localities, the officers (temporary and permanent) expressed their difficulties due to a recurrent lack of support from this institution. For example, while the Health Ministry sets certain quotas to be filled by the officers in different health programmes like vaccinations and pap-smears, they often did not provide the necessary instruments and the staff to attend all the population or even to meet the requirements of the Ministry itself.

> *For example, for tuberculosis they* (Health Ministry) *ask me to do 100 tests but do not give me the instruments. In the case of chronic patients they ask me to take 70 to 100 tests and they send the instruments but only to do 10. And at least I have 104 patients! And woe be unto you if you do not do them.* Maria, Permanent Doctor, Nexpan. (O35)

> *To be honest we really need a permanent doctor because sometimes a lot of people come, from the programme itself we are asking them to come for their (compulsory) consultation but we cannot give it to them. [They worry] they will get an absence from Oportunidades. So yes, the amount of staff influences a lot.* Andrea, Temporary Nurse, Cualcan (O36)

[55] This argument is, however, difficult to sustain since the system of the Health Ministry in Mexico is quite flexible and constantly changes officers from one community or position to another. It is also particularly difficult to sustain for these research sites since, on the one hand, some of the permanent officers in the sample had spent less time in the clinic than the temporary ones; and on the other hand, because the temporary director of the clinic in Cualcan had the same responsibilities as the permanent director of the clinic in Nexpan.

Indeed, in both communities this had an effect on the quality of the medical care provided and as requested by the conditionalities of *Oportunidades* (O36).

> *We are supposed to give a full check-up to the older [recipients], their body mass index, glucose, everything. But now, for example, we do not have the instruments to perform them. (…) Many people only come twice a year for their consultations, and if we do not have the tools for detection, they leave without being checked, and we will see them only until the next term. (…) Also the lack of staff implies you cannot focus too much in each of the many recipients that come for their compulsory consultation because outside you have other 20 ill people waiting*. Diana, Temporary Doctor, Nexpan. (O37)

As this quote also suggests, the lack of support from the Ministry in the provision of staff increased the pressures officers endured as well as their workload in paperwork and consultations.

Another important frame set by the Health Ministry could be its procedures and values. The narratives of officers also suggested the ministry offered a contradictory platform over which they could work on.

> *In the central offices there is one coordinator for each programme so each month that I go to deliver my reports they start asking, "why didn't you do this or that?" And for the programmes [I had greater output in] they say "Oh no, but in this one you did more, I am going to erase some here because they should be 50, not 100". So you think, what about my productivity in these other programmes? This is the type of logistics I do not agree with.* Maria, Permanent Officer, Nexpan. (O38)

> *I've been reprimanded because I delivered 447 consultations this month and they* (Health Ministry) *told me that I have to reduce it to half. And I asked them "why? Is it wrong that I am giving so many consultations?" "Yes, because when the permanent doctor arrives 'he' will not want to give as many consultations as you are and 'he' will not be liked (by the town)". I don't understand the way the ministry thinks, their norms. Because it is not possible that they are denying the… I want to work, I am not complaining, on the contrary. I happily delivered them a good productivity and they tell me this.* (R: And do you think that other doctors would not be able to do what you are doing?) *With organisation yes, we have enough time, and giving quality consultations to people.* Lorena, Temporary Doctor, Cualcan (O39)

In Nexpan, the director of the clinic expressed how the Health Ministry was only interested in obtaining the exact quotas requested and instead of reinforcing any other achievements from the officer, they erased them from her reports. In Cualcan the Health Ministry also reprimanded the officer for giving a larger number of consultations. This was not because of a concern with the quality of each consultation, but a concern that the next officers will not be willing to give the same amount of consultations and the town would notice. Thus, based on these two accounts, the discourse and procedures of the Health Ministry risk prioritising filling up quotas and numbers over the health of the patients. This contradictory approach, however, could have an influence on the attitudes that medical staff, especially permanent, develop over time.

An interesting implication of this finding is that the relationship between front-line health officers and their superiors at the health ministry is yet another relational context implicated in the final outcomes of the programme in people's lives. The hierarchical relationship perhaps too usual in this kind of institutions, the amount of pressure imposed over front-line officers and their expected obedience to rules that sometimes are blind to the challenges of implementation, can indeed have critical consequences on the terms of a relationship further down the chain: the relationship between front-line officers and their clients.

### 5.5.3 Relationships among staff and relationships within localities

Another reason for the opposing approaches by permanent and temporary officers seen in the two communities could be the result of a dynamic between the staff that is relationally reinforced in each context. This relational effect was particularly evident in Nexpan where the director of the clinic was characterised by both recipients and medical staff as very 'strict' and with a 'difficult personality'. This translated into the exercise of power and authority which could have an effect on the approach that other medical staff needed to have towards her and towards recipients.

> (R: How have you been feeling working here?) *I have liked it… I mean, the doctor (Maria) has a very strong character, not everyone adapts to her so each person needs to find the way of coping with working here.* Diana, Temporary Officer, Nexpan (O40)

(R: When there are tensions because of the workload can you easily talk to Dr. Maria?) *Mhmm… well, it is a little difficult (laughs) because she has a very strong character. When she is stressed and has a lot of pressure she has a very strong character. But once her tension is relieved, maybe you can go talk to her and try to reach an agreement. I think one needs to give in because if you don't the problems keep growing*. Clara, Permanent Dentist, Nexpan (O41)

These testimonies depict a low communication with the director of the clinic and tension between the staff. By highlighting the strong personality of Maria, both officers imply that her exercise of power makes the relationship between staff more arduous. Thus, in order to have a better relationship with the director it is possible that the officers needed to abide with her way of approaching things ("one needs to give in"). Indeed, Diana suggested I should take this approach if I wanted to conduct my research in the clinic. The following quote was extracted from a point in the interview where Diana is explaining what happens during a consultation of *Oportunidades*.

(R: Actually I hope it is possible for me to observe a consultation) *Well, unless you ask the patient for permission… but do not even dream that [Dr. Maria] will let you see. Actually, to be honest I don't think that she will allow you to have much access to the clinic. I think that if you want to see anything you would have to become her ally, because if you don't it will be very difficult for you. (…) She is not very open. Perhaps because is not convenient for her either, because there are many things that… you will notice yourself. (…) Also, a permanent officer will not be able to tell you much because maybe the doctor could do something [to them], you know?* Diana, Temporary Officer, Nexpan (O42)

This relational dynamic in the clinic might have led officers to find ways of coping with the working environment including accepting and reproducing the attitudes that Maria had towards work and the recipients. This was clear to me since the first day I arrived to the clinic to present myself to the staff and to the director of the health centre, Maria. As I introduced myself to Maria, she asked very detailed questions about me with an authoritarian and annoyed attitude and then, since she was busy, she abruptly asked me to come back at 2 p.m. with a list of documents to prove my identity. Later that day I came back and Maria was in her office accompanied by two officers, a temporary doctor (who finished her internship that week) and Ana the permanent dentist.

As I came into the room Maria ignored me and only told me to sit down on a stool. Then, without looking at me she extended her arm requesting the documents I was

carrying in a folder. At the same time she introduced me to her assistants and asked me to explain what I was researching. As I was starting to explain she interrupted saying that she was very busy and I had better be clear about what I was doing and what I wanted there. I started again and also mentioned that I wanted to be able to attend the *Oportunidades* workshops to get to know the recipients and that I would be happy to help in the clinic in anything that was needed. To this the doctor laughed and said, “But you are an economist aren’t you? You don’t know anything about medicine, so there is very little you can do here, except for buying us breakfast or something (laughs)”. Ana (permanent dentist) gave chorus to Maria’s sarcastic laugh by laughing with her. The temporary officer, on the other hand, had an expression of amazement and discomfort. At the end of what was probably a five minute meeting she mentioned that if she was not around the only person that would have the authority of letting me in the clinic and sharing information was Ana, and that she would share things under her own criterion.

This scene clearly shows a relational phenomenon between the officers that could have an influence on the relationship permanent officers in Nexpan have with the recipients. In this scene, Ana was the only one explicitly supporting Maria’s humiliating and sarcastic attitude towards me which in the end proved to give her privileges that no other staff had, being her right hand. It is possible that the hierarchical relationship observed in the officer’s accounts of recipients also happens in the relationship between staff. Therefore, in order to avoid being in the lowest steps of the hierarchy, the staff needed to reaffirm and support the attitude of Maria towards me (in this case) but also towards recipients.

In contrast to this relational sphere, another relational phenomenon that could influence the relationship between officers and recipients was the ability of recipients as a group to organise themselves to voice their opinion or complain about any wrongful treatment received or inadequate procedure conducted in the clinic. As argued above (section 5.4.2), in Cualcan, the people were known for their collective strength against cases of injustice. This reputation transcended the locality itself since, when I was choosing it for the research, people in the city of Puebla warned me of the ‘political’ and ‘aggressive’ attitude of the locality, trying to dissuade me from going there. Even though I never witnessed this kind of treatment, the people in this community did transpire a personal dignity and collective unity that is uncommon for mestizos in the country. In contrast, in Nexpan, participants constantly displayed attitudes and feelings of defeat, frustration, submission and powerlessness against mistreatment. The town was larger than Cualcan and more accustomed to life in a

city, thus people seemed to be less supportive and close to each other, and thus had less ability to organise.

### 5.5.4 The wider culture of discrimination in Mexico

These relational phenomena could also be shaped by the larger culture of discrimination and stratification in Mexico. Discrimination in Mexico is highly pervasive, entrenched in the culture and traditions of the nation. Székely (2006) developed a thorough analysis of the phenomenon, confirming that Mexican society is based on practices of discrimination and devaluation of certain groups that are reproduced through cultural and family values. According to his data, being indigenous (1st) and having a low economic position (3rd) are major causes of discrimination in Mexico. These categories clearly describe the cases of the recipients in Cualcan and Nexpan respectively.

The National Council for the Prevention of Discrimination (CONAPRED in Spanish) confirms that while 64.6% of people in Mexico consider themselves as *morena* (darker skin), 54.8% accepts that people are highly discriminated against by their skin colour and another 24.9% considers that there is some discrimination (CONAPRED 2011). This Mexican ideology can be sufficiently important to influence the attitude of officers towards recipients, increasing their need to clearly distinguish themselves from recipients by imposing hierarchies and having attitudes of superiority. Indeed, Székely found that the spaces in which people perceived greater discrimination included the work place, schools and public hospitals. Therefore, the attitude of permanent officers in Nexpan and those not interviewed in Cualcan could be induced by the larger culture of discrimination and inequality in the nation.

## 5.6 Conclusion

The aim of this chapter was to understand the perspectives of officers about their relationship with the recipients of *Oportunidades*. The main findings indicate that the terms of the relationship are directly bounded by two phenomena. On the one hand, the discourse of conditionality of *Oportunidades* validates the officers' understanding of recipients as a captive population whose role is to comply with the conditionalities. The officers, in turn, consider themselves as those who regulate, enforce and mediate these conditionalities. On the other hand, the identity of officers as medical staff was

another fundamental frame, especially conditional to the job title of the officer as contract-based (permanent) or temporary (intern). These two aspects provided a direct structure to how interactions between these two actors took place.

The analysis also suggested two opposite styles of relationship. In this sample, permanent officers mostly promoted a relationship of obedience and hierarchies. This was evident by their hostile verbal descriptions of recipients and authoritarian descriptions of their procedures of policy delivery. Permanent officers (primarily in Nexpan) considered it necessary to exert control and power over recipients, expected them to comply and behave in certain ways, and expressed greater disengagement from their needs.

Temporary officers, in contrast, usually promoted a relationship of reciprocity, exerting their authority not through power but through communication and empathy. Temporary officers focused on the positive aspects of the relationship, recognising the challenges they encountered and their strategies for solving them. Neither their narratives nor their schemes of policy delivery showed disengagement from recipients. Rather, they constantly reflected on the recipients' needs in terms of medical care and the economic support from *Oportunidades*. They showed an interest in helping recipients boost their fulfilment of the conditionalities. Finally, in contrast to permanent officers, they were aware that the way they engaged with recipients highly impacted their outlooks about the programme and the clinic, as well as their general wellbeing.

Interestingly, these results also highlight the overarching significance of relationality at different levels. In this setting, the roles of the wider culture of discrimination, health ministry, the relationship between staff and among the community in shaping the actions of front-line officers illustrate how a relationship in one context can become a structure in another relationship (officers-recipients). Chapter six analyses this relationship and its association with wellbeing from the perspective of recipients.

# 6. Wellbeing and officer-recipient relationships from the perspective of recipients

## 6.1 Introduction

The narratives of recipients about their experiences in *Oportunidades* provided a comprehensive picture of the nature of their relationship with health officers as well as the channels through which this relationship can influence wellbeing.

The importance of *Oportunidades* in the life of recipients was a predominant theme in the interviews. Hence, it is pertinent to commence this chapter by restating the centrality of the programme for wellbeing and briefly discussing the general attitudes recipients had towards *Oportunidades* overall and towards the health conditionalities specifically (section 6.2).

Subsequently the findings about how recipients perceived their relationships with officers are presented (section 6.3). This section delineates the similarities and differences between localities and from this information seven themes emerged about the characteristics of positive and negative interactions. These seven themes set the stage for constructing the Quality of Relationships with Officers scale (QoR) described below. The chapter concludes with the main interest of this study, understanding the possible consequences of this programme-engendered relationship on different aspects of the wellbeing of recipients.

This qualitative data (observations, interviews and focus groups with recipients) was also analysed in line with the critical realist approach taken by this study and a discourse analysis procedure that focuses on how language is used by recipients to characterise and construct the relationship with officers and its association with their wellbeing. Finally, as mentioned in the methodology (chapter four), no wellbeing approach was used to frame the conversations with recipients. Yet, the IWB approach did provide a valuable structure for the analysis of the transcripts.

## 6.2 Importance of *Oportunidades* for recipients

Before starting to describe this relationships from the perspectives of recipients, it is valuable to restate the centrality of the programme in their lives. Indeed, although many recipients recognised that the cash transferred received was small in relation to their needs, the programme on the whole was vital to improve their lives and those of their children. The findings in these two localities of central Mexico indeed resonate with those in other studies conducted in *Oportunidades* (e.g. Molyneux 2006) and

other cash transfer programmes (Attah et al. 2016, Samuels and Stavropoulou 2016). The following ideas were salient in most conversations with recipients in both localities.

*Oportunidades* was primarily important as an economic security net for recipients, especially at older age and for new families with children in school age. Recipients showed how the cash transfer was used for the purposes it was intended to in the programme's design, but more importantly, that it allowed them to live better in times of crisis as well as invest for the future.

> *When our support arrives I always save it. Whatever I earn from my (casual) jobs I use it for the week. But when I cannot get a job, I am not earning anything. That is why I save my support (cash transfer), because then is when I use it. Just a small part because the rest is for my children*. Jose, recipient, Cualcan (R1)

> *We (husband and her) rely on the support (cash transfer) of Oportunidades because with it we can buy school supplies for our children, shoes, and uniforms. And what I get for myself I use it for food and kitchen utensils. This has allowed us to use everything my husband earns to save and with time we were able to build this house*. Jacinta, recipient, Cualcan (R2)

Many recipients expressed how the economic support was not only important to buy material assets, but also for their subjective and relational wellbeing such as reducing feelings of shame in their children because now they could go to school wearing shoes or have some extra coins for lunch. Mothers also experienced less shame because with *Oportunidades* they could send their children to school in better conditions and happier.

> *My family (children) was very excited when we got into Oportunidades because they saw how other children already receiving it dressed better and brought snacks to school. They also wanted to buy those snacks but I didn't have money for that. Now I can afford it, it is not much but these little things are something, I save every week so they have those little things*. Agustina, recipient, Cualcan (R3)

Resonating with the findings by Adato (2000), the participants of this study expressed how their entrance to *Oportunidades* promoted their social connectedness through interactions with fellow recipients during health workshops and other meetings of the

programme. This was especially relevant to *vocales* who expressed that even though their responsibilities increased with the role, they have learned much from interacting with fellow recipients, speaking in public and building new relationships.

> *The moment I entered Oportunidades my life changed completely because before I had contact with no one, I had no friends and talked to no one. The programme helped me a lot. I have been a vocal for 4 years and I am really thankful it arrived in my life. I feel taken into account by recipients and other vocales. I feel important, respected. Many good people came into my life thanks to the programme*. Maya, vocal, Nexpan (R4)

> *I made many friends in Oportunidades and now that I am a vocal I feel very well because I can help [fellow recipients]*. Sonia, Vocal, Cualcan (R5)

Indeed, many *vocales* perceived the whole experience as empowering and expanding their capabilities and wellbeing in different ways, such as obtaining social recognition. The health workshops received were also perceived as empowering and supportive of their competence and self-worth because they increased their knowledge and information about health and (sometimes) psychological aspects that they can apply in their lives and in their relationships with others.

> *I do not see the workshops as an obligation or as if it implied a huge effort to attend because we learn a lot from them. We get information about diseases, how to treat them, and what are the symptoms. There are many things we don't understand about illnesses and this knowledge can help us know what to do. The workshops are very important*. Sonia, vocal, Cualcan (R6)

The opinions and attitudes of participants towards the conditionalities of the programme (health and education) were in general positive. Many recognised the responsibility they had acquired and showed interest in complying. Although sometimes home and work duties made it challenging, especially for women who had a conflictive relationship with their husbands or those who had to stop working for the day in order to comply with the programme.

> *The workshops are every month and we already know the dates we must attend. We just need to get organised to arrive on time. The same happens with the yearly consultations. It is easy to get the whole family organised because we know from the start of the year when is our turn. So we have time to prepare*. Isabel, recipient, Cualcan (R7)

*Since I entered the programme I have to hurry up with my chores at home to arrive to my workshops in the clinic.* (Researcher: How has your family reacted to these changes?) *(Lowers voice) At first my husband didn't like it. I explained that the programme was helping us; it is giving us back a little bit of what we pay in taxes and electricity. But now I just have to ask him (permission) when I have to leave (home) for the programme*. Paty, recipient, Nexpan (R8)

*The only problem [about the conditionalities] is that, as my fellow recipients say, they summon us very often. But we have to work and we have to be asking for permission (to miss a day of work) every time they call us. In some [jobs] they give you permission but you stop earning (the income of the day). But sometimes if they (boss) see that it is often they stop allowing you [to miss work]. Besides, every time I go to the clinic, if I want to take a bus it is 12 pesos return and with that I could buy at least 1 kg of tortilla. So instead of spending it on the bus I rather walk* (it took her one hour walking one way to arrive to the clinic). Lili, recipient, Nexpan (R9)

These quotes show that women often juggled between their personal duties as housewives, their employment, and the activities of the programme. For instance, in both localities the workshops were scheduled at 14:00 hours on a weekday, which assumes that women either do not work or are able to leave work to attend their meetings without economic repercussion. Yet, this was usually not the case especially in Nexpan since many women worked in informal jobs like domestic workers or farming where the salary is earned by the day or the number of crops collected. If they miss a day of work, they forgo a day of salary (see e.g. Álvarez et al. 2008). Hence, complying with the conditions sometimes entailed adapting their lives to have the flexibility the programme requires. This is part of the contradictory gendered bias of *Oportunidades*' design Molyneux (2006) identified.

In terms of their experiences complying with the compulsory medical consultations, many participants emphasised that these were brief and often required considerable waiting time. This was primarily in Nexpan where the hours for the compulsory consultations of *Oportunidades* were not separated from the general consultations in the clinic, which started at 9:00 a.m. (not at 8:00 a.m. as officially stipulated). Hence, to be within the 20 consultations conducted in the clinic in a day, recipients (and general patients) had to queue from 7:00 a.m. and sometimes the last recipient/patient to arrive in the morning left the clinic at 1:00 p.m. In Cualcan, in contrast, the clinic had two hours reserved every day for the compulsory consultations

of *Oportunidades* (between 12:00 and 2:00 p.m.). Therefore, recipients spent less time in the clinic waiting for their turn.

In the conversations about their activities in the clinic, some participants expressed feeling used and pressured by the way health officers implemented medical procedures that were not part of the compulsory activities of *Oportunidades* but rather part of the larger agenda of the national health ministry.

> *The health officers constantly blackmail us. They need to apply their own procedures and just because we have Oportunidades we are required to accept them. For example, doctors have certain goals they have to achieve. But then they think, 'since the women in Oportunidades have to come to the clinic, let's do the procedures on them, fill our quotas with them'. The procedures are good for us, but some people don't want to receive them and they feel pressured by the programme. The doctors use the programme to pressure us*. Sonia, vocal, Cualcan (R10)

A few recipients who participated in the *faenas*, the informal conditionality of the programme, expressed a similar feeling.

> *[What I like about Oportunidades] is the support (cash) and the workshops. The workshops teach us about diseases and self-esteem, to be a better person. What I don't like is that people take advantage of us as recipients. For example, we are the only ones in town who take part in the health committee of the clinic.* (Researcher: Who takes advantage of this?) *The people who do not receive Oportunidades and the (chief) doctor of course (laughs). She promotes it. She says that because we receive the cash and the workshops we have to support her whenever she needs something in the clinic. It is compulsory for us, she demands it*. Luisa, health committee member, Nexpan (R11)

In both localities, the group of recipients carrying out the *faenas* were identified as *members of the health committee*. In Nexpan, they were rotated once every year following the list of recipients by surname. The health committee members conducted work in the clinic every day. In Cualcan, they were rotated every two months based on voluntary participation from each group of the workshops and conducted work in the clinic every day.

In sum, *Oportunidades* is considered essential for their lives and the lives of their families in terms of the income, medical attention and knowledge they receive from the workshops. However, as the last sentences of quote R11 shows, when talking

about the health conditionalities, recipients in both localities repetitively mentioned their relationship with doctors and nurses. This is further explored next through how participants recount their relationships with the health officers in both localities.

## 6.3 The experience of relationships with officers from the perspective of recipients

In general, having a good relationship with officers was important for recipients for two reasons: to receive adequate and timely medical attention and because officers were seen as having significant power over their stay in the programme. Indeed, recipients perceived officers as strong figures of authority in the delivery of the health conditionalities, particularly the chief doctors or heads of the clinics (Dr. Lorena in Cualcan and Dr. Maria in Nexpan) since they controlled the procedures of the clinic and the monitoring of the conditionalities.

> *Sara: I do think it is important to have a good relationship with the medical staff because the clinic is the first place we would go if we have an ill (family member). Especially families like us who have scarce resources, and if we don't have a good relationship with them they will not treat us.*
>
> *Gloria: I also think it is important because that way whenever we need a favour they (health officers) will not say no.*
>
> *Researcher: What kind of favour would you ask them?*
>
> *Julia: Yes, for example, if we have [someone] ill and we do not have a way of bringing him/her to the clinic, you can ask the doctor the favour of doing a house visit or to refer him/her to the hospital.*
>
> *Carola: I think it is important because receiving Oportunidades depends on them. I mean, they fill in the S1 formats (attendance records).*
>
> Cualcan, Focus Group (R12)

> *(…) because the doctor is the only one who signs (the attendance record), the only one who authorises anything.* Areli, recipient, Nexpan (R13)

In this sample, only a couple of recipients perceived the health services received as an entitlement. Those recipients were *vocales* who tended to have more knowledge about the programme. However, recipients expressed more frequently that receiving

the services was the result of a process of negotiation with officers, a process that improved if recipients made an effort to have a good relationship with officers.

In addition to the role of health officers as key mediums through which recipients benefited from the programme - not only in its health component but also the possibility of remaining in the programme as a whole - the most salient finding was that recipients frequently evaluated their interactions with officers beyond the quality of the medical attention provided. Instead, their concerns were primarily directed to the treatment they received during the consultations and workshops of *Oportunidades*. The treatment was, in turn, significantly related to the perceived attitudes and behaviours of doctors and nurses through which the workshops and health check-ups were conducted.

> (Researcher: Can you describe your experiences during a compulsory consultation of *Oportunidades*?) *Well, it depends on the doctors' treatment. Because sometimes Dr. Maria (chief doctor and permanent officer) never conducts a check-up, she only kind of listens to you, she doesn't examine you and just gives you medication. But the intern is nice and attentive… we always trust interns more. With her (current intern) we can talk, tell her how we feel, she listens, and she conducts a check-up. She asks where it hurts or what is going on. Dr. Maria doesn't do that*. Cecilia, vocal, Nexpan (R14)

> *I really like going with Dr. Lorena (chief doctor and temporary officer) because she is a good doctor, a good person, she is very kind. (Researcher: What makes her a good doctor?) She never scolds, she greets us kindly and talks to us nicely. She doesn't say bad things to us*. Lisa, recipient, Cualcan (R15)

The former excerpts illustrate how when asked about their experiences during the compulsory consultations of *Oportunidades*, recipients often conflated good medical attention with a good interaction and treatment from the doctors.

They also confirm the findings from the qualitative study with health officers about the differential relationship with temporary and permanent staff (chapter five). Although is natural that interactions vary between staff, for recipients it was also their position in the clinic that was the most salient distinguishing factor. In both localities, the participants of this study usually perceived relationships with temporary staff more positively than that with permanent staff. This also entailed that the experiences of recipients in Cualcan and Nexpan were strikingly different given the characteristics of

the health officers working at the clinics when the fieldwork was conducted[56]. In the following sections, the results from each locality are discussed separately.

### 6.3.1 Officer-recipient relationships in Cualcan

In Cualcan, the indigenous and rural locality of this research, participants tended to portray their interactions with officers in positive tones. They described the relationship as one of communication, kindness, dedication and empathy.

> *The (chief) doctor we have now is very kind. She treats you very well, listens and is approachable. Besides, if you ask her something she gives good explanations. Yes, because the previous doctor was very rude, if you asked him anything he yelled at you from the start.* Jaque, committee member, Cualcan (R16)

> *There is good communication with the doctor and with the nurse. I knock on the clinic at any time (of the day) and the doctor treats my child. Yes, at any time. She even tells me, 'I am available if you need me. I am here to treat you'.* Marisa, recipient, Cualcan (R17)

Recipients in both localities particularly valued officers that were kind in the way they approached them, explained the procedures and medications they were prescribing and were patient towards the questions recipients asked. When the relationship was perceived in this way (in both localities), recipients reported greater trust in the clinic and feeling more confident about approaching the doctors and nurses to discuss issues of the programme and of their own health. *Vocales* who are the direct connection between officers and recipients, also mentioned that it was easier for them to discuss issues of the programme with the current (temporary) officers.

Quote R17 also illustrates that participants particularly valued when officers were flexible with the timetables of the clinic by listening to the reasons provided by recipients. However, most recipients were also accepting when the officers needed to place boundaries or be strict, for example, in the way they asked them to take a medicine or be punctual for *Oportunidades* workshops. The key was the way officers

[56] As mentioned before, in Cualcan the health officers were mostly temporary (interns) while in Nexpan the officers were mostly permanent (contract-based).

approached them. They especially appreciated when officers showed concern towards them and took the time to explain reasons.

> *I like being in the health committee because I have seen how the doctor is very kind; she treats her patients very well. She used to give 30 or 40 consultations every day but recently she explained us (recipients) during the [Oportunidades] workshop that her bosses asked her to cut down to 20 consultations. And we understand. I really like how she explains things to us. Also when you arrive late for some reason and ask her if you still can get a consultation she says yes but if you wait after the people who arrived first get their check-up*. Jaque, health committee, Cualcan (R18)

Most participants in Cualcan felt comfortable with their relationship with the current chief doctor and nurse. Most of their discomfort originated from their interactions with one current nurse (permanent) and from experiences with former doctors (permanent). Overall, these recollections emphasised attitudes of rudeness, disrespect and verbal aggression as quote R16 displays. This was not only experienced one-to-one during the consultations but also collectively during the workshops and in the waiting area.

> *I have nothing against (current) doctors. I just didn't like the previous doctor because he used to get angry often and he got even with all of us! The whole town was not happy with him.* Marisa, recipient, Cualcan (R19)

> *The doctor was always saying (bad) things to us. He said we were opportunists (self-seeking)! That we are only interested in the cash transfer and we don't want to participate in our workshops and other activities! But you cannot say that!* Claudia, recipient, Cualcan (R20)

> *I get on very well with Dr. Lorena and nurse Andrea, but not with nurse X (permanent nurse) because she has a very strong temper and the same way of working as the former doctor. She yells at people*! Jaque, health committee, Cualcan (R21)

Negative relationships with officers were particularly problematic for those whose first language was Nahuatl and who had problems speaking or understanding Spanish. Indeed, recipients in Cualcan expressed experiencing a lack of empathy and patience towards indigenous people.

> *Since officers are treating people who speak an indigenous language, I think*

*that they should make an effort to understand us. Sometimes they get in a bad mood because people only speak Nahuatl and doctors don't understand them and they say, 'no, it is better if you leave!' That happened in front of me, which is why I am telling you. I understand that there are many people in the clinic, much stress and all. But this is no way of treating people.* Sonia, vocal, Cualcan (R22)

*The doctor's treatment affected me because you couldn't even talk to him, ask him a question or any information because he would yell at you or say things to you. A lot of people were afraid of him… Sometimes I thought about those who don't speak Spanish, especially the elderly, like my mother. Imagine if my mom went (to the clinic) by herself? How would he have treated her? He would probably send her off without healing her.* Jaque, health committee, Cualcan (R23)

In sum, in Cualcan recipients reported having a positive relationship with the officers currently implementing the conditionalities of *Oportunidades*. According to recipients, this relationship was characterised by communication, respect and dedication. However, despite current positive relationships, recipients problematized interactions with permanent officers in the clinic. These encounters were characterised by yelling, bad communication, mistreatment, insults and lack of empathy particularly towards recipients who did not speak Spanish fluently.

### 6.3.2 Officer-recipient relationships in Nexpan

In contrast to Cualcan, in Nexpan (the semi-urban and mestizo locality) participants conveyed negative encounters with health officers considerably more frequently than positive encounters. As in Cualcan, when participants perceived the relationship as negative, they described being mistreated, yelled at and publicly humiliated.

*Sometimes [the chief doctor] explodes with the first who crosses her way. That time when she yelled at me, I felt very embarrassed because the clinic was full. I expected her to understand and to listen to the reasons why my daughter missed the (compulsory) appointment (she had a school exam). I didn't receive the cash transfer this time, so I will just wait and if I do not receive it again, well... The vocal told me to talk to the doctor about it and to bring her a form, but no way! If I go to the clinic, she will yell at me!* (Researcher: But not going could

mean that you would be taken out of the programme, wouldn't it?) *I'd rather wait and see, if I do not get it again I might bring the forms or I (might) just stay like this.* Areli, recipient, Nexpan (R24)

*(…) there are ways of expressing yourself, 'I apologise but I cannot treat everyone' (kind tone) But no, she (chief doctor, permanent) says 'I do not want you telling me that you want your little prescription, or whatever. I have told you that I cannot treat you all, I can only treat 18 [patients], and I don't want to know anything else about it ok?!' And there she is mistreating us! (…) She also said that we should not ask her any question, that we are not children*. Gloria, recipient, Nexpan (R25)

The previous quotes start to point towards a rather problematic relationship involving mistreatment that dissuaded recipients into going to the clinic. Yet, in this locality, the interactions with permanent officers were described in even stronger hierarchical terms, including issues of threats and abuse of power.

*Maybe is wrong for me to say this, but... the doctor abuses her position a lot. She puts conditions to signing the attendance record depending on whether she likes you or not, or sometimes she might simply find an excuse not to sign it. And she forces us to do things!* Luisa, health committee, Nexpan (R26)

*I kindly asked her (chief doctor) to come home to see my son, because he couldn't move and I didn't have a way of taking him, no one to help me*[57]*. She said she didn't have time, that she wasn't at the disposal of the people, that she was there to work in the clinic and not to treat people in their homes. I did get upset and I told her that I thought that this was the reason she was sent here. I told her, "So, if I am dying, you will treat me only if I arrive here (clinic)?" From there on, she started telling me things, she started telling me that she will not treat me and even that she will expel me from the programme.* Cecilia, vocal, Nexpan (R27)

Both excerpts exemplify what seemed to be a constant in this locality, a doctor that used the programme as a tool to assert her power and authority in the clinic. This was primarily discussed in relation to the chief doctor, but the observations at the clinic and the findings from the interviews with officers suggested that the dynamics within the clinic as a whole seemed to follow a similar approach.

[57] Unfortunately, her son died a month after this interview took place.

There was an event at the clinic that struck me as a faithful illustration of the kind of relationship between officers and recipients in Nexpan. One day during my observations, I asked a lady waiting for her consultation where was the toilet. She pointed towards a room whose entrance was covered up by a large piece of thin wood and in front a big table to sustain it in its place. She explained that the toilets have not been working for a while although she was suspicious that this was true. Another day, early in the morning with the clinic almost empty, I asked the nurse (permanent) whether there was a toilet I could use. The nurse showed me the way towards the same toilets the recipient and I talked about days before. While the nurse and I were moving the piece of wood for me to get in, I asked her whether the toilets were working, to which she replied, "(laugh) they do work, we just don't want the people to use them because they don't know how to use a toilet". Even though no one else heard this statement, I felt rather uncomfortable because the small number of people who were in the waiting room at the time appeared to realise the situation: I was allowed to use the toilet but they were not.

In the interviews and focus group with recipients that followed, the issue of the toilets was mentioned and perceived as an important sign of their lack of rights in the clinic and the discriminatory attitude of the health officers towards them.

> *Paula: So many people come (to the clinic) and we are all willing to donate 5 pesos for the toilets to work, because they don't work! Apparently because there is no money!*
>
> *Bere: They do work! I just became part of the health committee and they (officers) always say the toilets don't work, but they do work! Some of us came inside to check (laughs). Because, believe it or not, for example me, I am pregnant and I need to use the toilet fast. And any person who is ill or older, they need it fast.*
>
> *Brenda: And we (recipients) are (waiting) in the clinic since 7:00 a.m. for us to get a consultation. And there are some people that get to leave the clinic until 1 or 2 p.m., where are they going to the bathroom?*
>
> *Uma: They (officers) say that the [toilets] don't work because it smells bad… I mean, they say… 'We (officers) have no reason to be in our workspace smelling things'.*
>
> Focus Group, Nexpan (R28)

> *"We do not have rights in the clinic, we do not even have the right to use the toilets".* Carlos, health committee, Nexpan (R29)

Participants had different reactions toward what could be described as a hierarchical and discriminatory relationship. In their attitudes detected during the observations and their expressions in interviews, many recipients in Nexpan seemed to feel disempowered and take a submissive behaviour when interacting with officers.

> *I cannot complain about the clinic. Yes, sometimes doctors have a bad temper for random reasons, but as the (chief) doctor has told us, "as long as you do not protest or contradict me when I tell you something, I will assist you". But sometimes the doctor has such a mood that no one can stand her. Just a month ago she had a problem with other beneficiaries and I was there. The beneficiaries were talking to each other and laughing, but between them. And the (chief) doctor thought they were laughing at her and started to yell and swear at the beneficiaries! (Researcher: And what did you do?) Nothing, I just sat there. We cannot say anything to her*. Cecilia, vocal, Nexpan (R30)

Carolina unconsciously endorsed the authoritarian attitude of the doctor by partly reporting satisfaction with the clinic's services ('I cannot complain about the clinic') and accepting the doctor's statement of superiority over recipients. This was further demonstrated by her inaction to the event she describes in the clinic despite being a *vocal* of the programme.

In contrast, other recipients were well aware that these negative attitudes of health officers were an act of discrimination and abuse of power, although it was not clear how they would react to a conflict with an officer. In the following quote, a *vocal* and I were conversing about what she described as the 'strict' personality of the chief doctor in terms of the procedures for monitoring the compulsory consultations and her way of coordinating the *vocales* (including her) and 'telling them off'.

> (Researcher: How do you feel when she treats you like that?) *Bad. No one likes to be yelled at all the time. Besides, I hate injustices. But I cannot fight back even though I am upset. We cannot fight back much because of the way she is. She has said it herself, 'I am the doctor and none of you will tell me what I have to do, that is why I studied'. And unfortunately, what can we reply to that?* Lucy, vocal, Nexpan (R31)

> *They act as if they always have the right to talk… people who are in power always think they have the right to have an opinion, the right to everything. Oh, but they are wrong, I could be humble and poor and whatever you want, but I am against this kind of discrimination*. Carlos, health committee member, Nexpan (R32)

In general, the data suggested that the threats and discriminatory actions of officers (using the words of recipients) caused recipients to prefer not to react directly or indirectly to the mistreatment. Many stated being afraid of losing the programme and of some other kind of retaliation if they reported officers to the larger authorities in the health ministry or in *Oportunidades* (e.g. R43, R44, R45, R48).

Overall, the narratives of recipients in Nexpan embody an extreme case of a negative relationship between recipients and officers. The qualitative data in this locality suggested that this negative relationship was characterised not only by yelling, mistreatment and lack of communication as in Cualcan. It also included more powerful encounters involving threats, abuse of power, discrimination and violation of people's rights. In reaction to this, the narratives of recipients expressed feelings of fear, disempowerment, mistreatment, discrimination, and disrespect from officers, particularly the chief doctor with whom they interacted more often and who was the principal authority in the implementation of the programme.

### 6.3.3 Positive and negative interactions

As is possible to identify from the sections above, the narratives of recipients in both localities often had a difficult time separating the quality of the medical attention provided by the health officers, from the quality of the relationship with them. In many ways, both the personal and professional aspect of this relationship was essential for participants to feel that their interactions with officers were positive. As a result, many quotes captured both aspects of this relationship, the personal which is associated more directly with the attitudes of the staff, and the professional associated with their roles as providers of medical attention and as supervisors of the conditionalities.

This is reflected in the seven themes that emerged from the ways in which recipients characterised positive and negative interactions with doctors and nurses in both localities. The seven themes are: *Communication, Confidentiality, Time issues, Respect or Humiliation, Dedication or Care, Abuse of power,* and *Discrimination*. The

themes do not follow any particular order, although it is important to emphasise that the more salient themes were *Respect or Humiliation, Communication,* and *Dedication or Care*. Previous sections have exemplified some of these themes through quotes, thus they are not repeated here.

These themes were the basis for constructing the Quality of Relationships with Officers scale (QoR) and thus the resulting questions reflecting each theme are presented in Table 6.1. It is important to reiterate that the wording of the questions followed those used by participants during the interviews and focus groups. Although the wording of some questions could be considered strong for a survey question, they were included due to the importance given by recipients.

**Table 6.1** QoR indicators

| Item | Question | Theme |
|---|---|---|
| qor1 | Do you feel that the way you are asked to comply with the conditions of Oportunidades by doctors/nurses is appropriate? | Abuse of power |
| qor2 | Thinking about your experience in general, do you feel that the doctors/nurses pay attention to you? | Communication |
| qor3 | Do you feel that the doctors/nurses treat you with kindness and respect? | Respect |
| qor4 | When you go to the clinic, do you feel that the doctors/nurses explain things appropriately? | Communication |
| qor5* | Do you feel the doctors/nurses abuse of their position? | Abuse of power |
| qor6 | When the doctor/nurses say or do something you do not like, do you feel that you can say or do something about it? | Communication |
| qor7* | Have you felt discriminated during your consultations or workshops in the clinic? | Discrimination |
| qor8* | Have you felt scolded by a doctor/nurse in front of others? | Humiliation |
| qor9* | Have you felt insulted or humiliated by a doctor or nurse in the clinic? | Humiliation |
| qor10* | Do you feel that your privacy is respected by doctors/nurses in the clinic? | Confidentiality |
| qor11 | Do you feel that the waiting time you spend to get a medical consultation is worth the while? | Dedication or Care |
| qor12 | When you go to the clinic, do you feel that you receive an adequate medical revision? | Dedication / Care |
| qor13 | Do you feel that the doctors and nurses try to give you the best attention? | Dedication / Care |
| qor14 | Do you feel that the doctors and nurses are sensitive to you and your needs? | Dedication / Care |

The theme of *Communication* is associated with the importance given by recipients to having a positive dialogue with the health officers during the activities of

*Oportunidades*. For recipients in both localities, this entailed that the doctors and nurses took the time and effort to explain things appropriately to them during the consultations and workshops (qor4), but also that they pay attention when recipients are explaining their symptoms and feelings (qor2). The importance of having good communication was also associated with the extent that the recipients truly felt the confidence and possibility of expressing their complaints and needs to the officers related to the procedures of *Oportunidades* (qor6) (e.g. R14, R16, R17, R24, R25, R40).

For the participants of this study a central aspect of good quality medical attention was also related to the way doctors and nurses handled the consultations and administrative procedures around them. Recipients particularly emphasised that the waiting time in the clinic was not worth the while given the quality of the medical consultation ultimately received (qor11). They also mentioned concerns about respect to privacy and the *confidentiality* of their medical condition given the way some officers handled their cases (qor10). These are captured in the themes of *Time issues* and *Confidentiality*. The following quotes illustrate them.

> *Jara: They (health officers) want us to be punctual at 8 a.m. to get in the queue, but sometimes they are just standing there chatting away instead of hurrying up with the consultations so that they don't have us there waiting…*
>
> *Bere: (interrupts) until 1 p.m. (laughs)*
>
> *Judith: We haven't even had breakfast and we are waiting. Apparently, we have to wait until more people arrive, but they shouldn't do that. That is why I don't go there anymore, I prefer to pay for a private doctor.*
>
> *Brenda: Yes, we go because we are obliged to! (5 or 6 participants agree).*
>
> Focus Group, Nexpan (R33)

> *There is a nurse who during the workshops is ventilating the reasons why recipients need to report to the clinic. She says, 'X person needs to come for Y reason, and Z person has many months since she last came to check for this illness'. But these things are confidential! There was the case of a woman who was using contraceptives but her husband didn't know. Through the workshop the nurse asked to let her know that she needed to come check her contraceptive device and another recipient told her husband. When the woman arrived home the husband beat her very badly. A few days after, she asked me to talk to the doctor.* Marta, vocal, Cualcan (R34)

The next themes captured more personal aspects of the interaction with doctors and nurses such as *respect, dedication or care, abuse of power* and *discrimination*.

The theme of *dedication and care* reflects the importance given to receiving an appropriate and caring medical attention from officers. This was evaluated in terms of how much recipients felt the staff made an effort to give an adequate medical provision (qor12). Recipients also stressed the centrality of officers demonstrating sensitivity and empathy towards them during the workshops and the medical consultations (qor13, qor14).

> *The doctor we have now takes much care of us. Now if you cannot go to the clinic because you are pregnant or ill, she sends the nurses to look for you and see how you are.* She really cares about how we are doing. Jacinta, recipient, Cualcan (R35)

Probably the most important aspect of the relationship with doctors and nurses for recipients was feeling *respected* and not *humiliated* during their interactions with staff. Indeed, when recipients described what a positive interaction with the health staff entailed, they expressed the need to feel respected and treated with kindness (qor3). The opposite of respect was expressed as feeling shamed, yelled at or scolded, especially when this was conducted in front of others (qor9, qor8) (e.g. R24, R25, R30, R31).

On a more negative tone, recipients noted the significance of officers' *abuse of power* (qor5). As seen in the case of Nexpan, abuse of power was also associated with the way recipients felt officers compelled them to comply with the conditions of the programme. In many instances, recipients described the officers' attitudes as authoritative, imposing and sometimes aggressive (qor1) (e.g. R25, R26, R27).

Finally, discrimination was also a salient theme in both localities, in Nexpan towards recipients in general and in Cualcan towards indigenous recipients in particular (qor7) (e.g. R32, R46). In the focus group in Nexpan, the activity where recipients were asked to describe a positive and a negative interaction in three key words each, one recipient wrote the word discrimination in the negative list. During the collective ranking of the words in terms of importance, this is how the conversation took place (see table 6.2 for the words enlisted):

> *Bere: To me, all are important, all of them. But if I have to choose the most important to me are humiliation and mistreatment.*

*Paula: To me discrimination [is the most important]*

*Brenda: Yes, discrimination, because it is from discrimination from where everything else come from.*

*Vicky: Yes, discrimination (Reina and Jara agree)*

*Tania: I think it is Discrimination and Humiliation next (Rosy and Mago agree with humiliation)*

*Uma: But respect is also important (…)*

Focus group, Nexpan (R36)

**Table 6.2** Words describing negative interactions with officers. Focus Group Nexpan

| Word | Frequency (Individual exercise) |
|---|---|
| Mistreatment | 4 |
| Humiliation | 4 |
| Yelling | 4 |
| Bad temper | 3 |
| Disrespectful | 3 |
| Selfishness | 2 |
| Rudeness | 2 |
| Scolding | 2 |
| Aggressions | 2 |
| Threats | 1 |
| Make us feel bad about ourselves | 1 |
| Inferiority | 1 |
| Discrimination | 1 |

This activity shows how perception can be shaped by the relational dynamics that happen during a focus group. Indeed, while only one participant mentioned discrimination in the individual exercise, in the collective ranking (only partly reproduced in R36) discrimination was agreed to be the most important of all. This could probably be because of the compelling argument of Brenda who posited discrimination as the main cause of the other negative aspects enlisted.

As table 6.1 presents, all items in the QoR scale used the wording of the recipients' accounts in both localities with the objective of remaining as faithful as possible to their own experiences and perspectives. An a posteriori examination of the scale revealed that the resulting questions were quite variable in the degree of 'charge' they carried. Some questions were more neutral in their wording, others positive and

moderate, and others more negative and direct (e.g. the item on discrimination). The negative and direct tone of some items could be a limitation of this scale by tempering the participants' answers to questions that could be perceived as strong. In the future, negative worded questions should take a softer tone to avoid possible biases in the responses.

### 6.3.4 Ambivalent interactions with officers

Even though it was possible to identify the features of a positive and a negative relationship with officers from the recipient's standpoints, it is important to emphasise that there was also noticeable ambivalence, uncertainty and inconsistencies in this characterisation in both localities.

> (Researcher: How do you feel during the consultations of *Oportunidades*?) *Well, there are good days and bad days. I think when the doctors are in a good mood they are laughing with you, 'Tell me, how are you feeling?' But when they are in a bad mood! I don't know what happens to them. For example, one day I went to the Oportunidades [compulsory consultation] and my baby was ill. But the doctor made me choose between getting the Oportunidades consultation and taking my attendance or looking at my baby's illness.* Rosa, recipient, Cualcan (R37)

> *Mia: The first time you go to a consultation, and if you are lucky, she treats you well and you leave satisfied. But next time she treats you as if you were… So we think, 'what is going on? How are they like in reality?'*
>
> *Bere: Do you want to know what I think when I go to a consultation? I think I hope I find them in a good mood! (laughs). (Many laugh)*
>
> Focus Group, Nexpan (R38)

This ambivalence and inconsistency experienced by recipients makes it difficult to easily categorise a relationship as positive or negative even for recipients themselves. It underscores the fluidity and coexistence of both good and bad phases within one single relationship.

This coexistence also denotes how relationships often involve an active negotiation between the actors. The balance, however, can easily move towards the powerful

actor in the relationship, and in this particular context it appears that it is the officer who usually takes this position.

It was interesting to identify very few participants, especially *vocales* and men, who reported having a positive relationship with those officers that usually were portrayed by recipients as hierarchical and abusive. This prompted further analysis on the reasons behind this. The most relevant finding was that those recipients who felt/were more empowered and related to officers in a relatively assertive way were those who narrated better interactions. The next couple of quotes illustrate this in each locality. The first excerpt originates from a conversation with a male recipient in Nexpan who is remembering a conflict he partook in between a number of recipients and the doctor about some money recipients collected to make repairs in the clinic.

> *The doctor arrived saying, 'So you are saying that we (officers) stole the money? (Imitating a superiority tone) But say it! Because I can sue you for defamation!' That is what people are afraid of, with that (assertion) everybody shut up. And then I started talking. I thought, now I am going to play her own cards. I said, 'Doctor, you said, be respectful, allow people to talk. So now I ask with all that respect, allow me to talk. Doctor, how could you sue us?' And I told my fellow recipients, 'No one should intimidate you, if we all stick together, no one can intimidate us because we are united' (…) So then she saw my strength. What does she prefer, to have a friend or an enemy? A friend of course! So, she does not mess with me. I arrive to the clinic and she is like, 'Mr Carlos, how are you? Good morning'. But she does not treat everyone the same.* Carlos, health committee member, Nexpan (R39)

In Cualcan, the leader of the *vocales* and a woman with an authoritative presence recurrently expressed the same experiences. Here is an example.

> *[The former permanent] doctor was very difficult. He was difficult to talk to because he was always stressed out, in a hurry. When you (anyone) arrived (to the clinic) he asked, 'What do you feel?' and as you were telling him he was writing a prescription without explaining anything else. But he never treated me like this, probably because he knew how I am (laughs), or who knows. But there were many cases, very special cases of mistreatment in this community.* Sonia, vocal, Cualcan (R40)

These ambivalence and inconsistencies in the officer-recipient relationship are related to the 'luck' of the recipient, the 'mood' of the officer, and the personal

characteristics of the doctor/recipient involved in the interaction. This ambivalence and fluctuation is however difficult to capture in clear-cut positive or negative poles. This could imply that the positive and negative indicators in the QoR scale and on those used in wellbeing research to measure the positive aspects of social relationships such as support, are fairly simple characterisations of what happens in social interaction. Indeed, the quality of a relationship can fluctuate, be negotiated, and transform depending on various internal and external circumstances. These aspects of relationships are observed more easily with the use of qualitative methods.

## 6.4 The role of the relationship on wellbeing

The data presented earlier suggested that the quality of the officer-recipient relationships had an influence on the attitudes of recipients towards the clinic and the programme in both localities. Positive relationships improved the recipients' perception of the quality of the medical attention received. Having good interactions also increased the recipients' trust in the clinic and willingness to attend and comply with the conditionalities of the programme. However, when the interactions were negative, recipients preferred avoiding those physicians who were perceived as disrespectful or authoritative, and even to minimize their reliance on the clinic as much as possible. This entailed a real risk of losing the programme if it involved not complying with the attendance expected by *Oportunidades*.

If recipients or a family member fell ill, being mistreated in the clinic compelled them to seek other sources of health care such as private medical attention or traditional healers. Although avoiding the clinic for non-compulsory consultations does not risk losing the programme, these are potentially harmful for their health given the difficulty of identifying legitimate physicians, and their economic situation due to the costs of private care. However, for other recipients the negative encounters with officers was sufficient to dissuade them to remain in the programme altogether as in the case of Areli (quote R24).

In addition to the influence that this relationship could have on the attitudes of recipients towards the programme, the quotes that have been presented start to indicate other ways in which the terms of the relationship influenced the inner

wellbeing of participants[58]. This was more palpable when recipients perceived the interactions as increasingly negative. As mentioned in the methodology chapter (four), a wellbeing approach was not used to frame the discussions in the interviews and focus groups with participants. Yet, the recipients' accounts still pointed out possible channels through which their encounters with officers could influence different aspects of their lives and wellbeing. It was on the analysis of these conversations that the Inner Wellbeing approach was used and the main findings of this are presented here.

In general, feeling mistreated by doctors and nurses caused discomfort, distress and negative feelings in the participants who reported these interactions.

> *If I go to the clinic in pain, and they do not assist me, they tell me off or yell at me, well, if I am already feeling bad, then I feel worse. That is why some people look for other options... But people do not say anything because of fear... yes is mainly fear that if I say something the doctor will not take my attendance (of Oportunidades)*. Marta, vocal, Cualcan (R41)

> *She (doctor) always mistreats us. She never treats us right. Imagine, if someone arrives at the clinic sad because something happened at home, a problem or something, that one arrives to the clinic hoping to find her in a good mood. But if you find her in a bad mood, she treats you worse and that aggravates the whole situation. You leave (the clinic) feeling much worse. It affects your self-esteem[59].* Bere, recipient, Nexpan (R42)

Probably the most salient effect of negative and positive interactions on wellbeing was on the recipients' economic confidence. Indeed, many recipients mentioned that they were concerned about their relationship with officers primarily because officers monitored their compliance with *Oportunidades* conditionalities. However, when the relationships were more hierarchical, recipients' fear of losing the programme and thus the cash transfer was much higher.

> (Researcher: In what ways do you think the relationship with health officers could affect you?) *In many ways, primarily because they sign the attendance*

[58] Part of these findings were published in the Journal of Social Policy and Society (see Ramírez 2016)

[59] In the fieldwork, especially in Nexpan, some participants were comfortable with the concept *self-esteem* and used it spontaneously during the interviews (see R11, R48). After further enquiry, I learned that they picked up this concept from some workshops delivered by psychologists and organised by the *Oportunidades* programme.

*record and put conditions on everything. For example, they could decide not to sign my attendance record even though I attend, and just by not signing they can justify that I did not comply. Without the signature, I can be expelled from the programme and then I cannot attend my workshops and I don't get my support (cash transfer) either*. Gina, recipient, Cualcan (R43)

In a way, recipients perceived that remaining in the programme was not only determined by their own actions fulfilling the conditionalities, but by the officers' discretion to decide when to sign the attendance record or to accept proofs of absence. Hence, even if the monitoring role of the health officers is necessary for the implementation and regulation of *Oportunidades*, when the quality of this relationship is poor it could also endorse arbitrary decisions and abuses of power that ultimately have the opposite effect to what a cash transfer is intended to do: increase the economic confidence of the poor.

The quality of this relationship also influenced the sense of agency of participants. As the next quote shows (see also R24, R30, R31, R41, R44, R45, R48), as the relationship with officers became more hierarchical and power-heavy, recipients felt more discouraged to approach them to talk about any issues associated with the programme. Recipients also felt fearful of raising their voices when they disagreed with a decision made in the clinic, a procedure they felt forced to undertake or when they felt mistreated by officers. Overall, as officers became more authoritative, recipients felt less able to use their agency to change the situations they were involved in because of their participation in *Oportunidades*.

For example, in the next excerpt from Cualcan, a recipient is narrating how the previous permanent doctor behaved when his boss came to a town meeting organised to undertake a health campaign.

*When his boss came, he (doctor) showed off! Yes! And no one said anything; no one said how he was mistreating us. Everybody just stood there quietly! I told my sister-in-law, 'He mistreated you, tell his boss now and in front of him'. 'No', she said. And I think that is why we are in this situation, because we don't talk!* (Researcher: Why do you think you don't talk?) *Because of fear! Because people think that he is the doctor and that we are poor, so they think he will win.* Claudia, recipient, Cualcan (R44)

*One has to agree with her (chief doctor) in everything, be compliant. Because, for example, if she were to find out [that she is complaining of her in the*

*interview] she would take it against me, and she can even take me out of the programme. We have tried to issue a complaint before, but we don't know how but she finds out and asks who was complaining and why. So you believe in her threats. And we think, what can we do then? It is even worse when she threatens that she can sue us for defamation. How could we defend ourselves from that?* Luisa, health committee member, Nexpan (R45)

The previous quotes also show the role of identity in the interaction and the wellbeing of recipients (see also quote R46 below). Indeed, the officers' identities of doctors and educated contrasted with how the recipients perceived themselves as poor and uneducated. This contrast, which was often used by officers to assert their authority and difference from recipients, was indeed noticed by recipients and had an influence on their feelings of individual and collective empowerment. These quotes also start to point out to the effects that this relationship could have on people's sense of self-worth and competence.

The next excerpt comes from a discussion with the participants of the focus group in Nexpan after they performed a play to represent an interaction with health officers. I asked them to analyse the plot and the attitudes of each actor. This is what they said when analysing the performance of the 'recipient':

*Jara: She is very submissive! Because she… because we have no other choice.*

*Mia: Yes! Once I was in the clinic and a lady that was seven months pregnant was with the doctor. And when I was coming in and she was leaving, the lady asked the doctor: 'will you sign my attendance record?' And the doctor said: 'No, you will get an absence! I cannot believe that you have 7 children and you didn't know you were pregnant! Please, even the stupidest woman knows that!' I was shocked…*

*Researcher: What do you think about this situation? (Ask all)*

*Uma: She thinks that because she is educated she can…*

*Brenda: Trodden on us! (Others agree) Yes! Sometimes she says, 'How can you think you can tell me what to do? If I am the doctor, I studied. How could you give me orders if you are just peasants!'*

Focus Group, Nexpan (R46)

Feeling 'trodden on' by officers is a strong visual representation of how continuous negative and authoritarian interactions with health officers can influence the sense of

personal worth of the recipients of *Oportunidades*. Similarly, the passion and emotion through which recipients voiced these personal experiences reflected the weight of these negative interactions in the recipients' wellbeing. These emotions were not referring to casual encounters but to systematic patterns of events with important implications for wellbeing.

Positive interactions with officers had the opposite effect on the sense of competence and self-worth of recipients. A few recipients in Nexpan and Cualcan suggested how having a good relationship with doctors and nurses not only enhanced their self-confidence during their encounters, but also their self-confidence to cope with other relationships and events in their lives. For example, one recipient mentioned that having a good communication with the doctor and her support helped her feel more confident when needing to discuss issues of family planning with her husband who was against using any method. Similarly, the next quote presents the end of a conversation with another woman who is reflecting on the reasons why she feels more able to handle the bad relationship with her husband.

> *I told (my husband), 'if I had a place to live, you wouldn't enter my house again, because I am a woman and I respect and love myself.'* (Researcher: What has helped you feel so confident?) *I think it is thanks to the workshops from Oportunidades, especially with Dr. Y [former doctor]. She gave us talks about self-esteem, female diseases and the like. But she talked to us openly. At the beginning, we were shy because we weren't used to talk about those things. But when we started trusting her and talking to her constantly, we were more open. I don't know why they took her away from us. But yes, it was through her talks that I started saying, 'I will give it a try'.* Lili, recipient, Nexpan (R47)

Indeed, the extent to which the activities of *Oportunidades* can promote the wellbeing of recipients is not only associated with the knowledge provided, but also with how officers relate to recipients during these activities.

It was, nonetheless, the negative interactions involving threats, abuses of power and discrimination, which had the strongest and most overarching influence on the wellbeing of recipients. This is illuminated by another quote from the focus group in Nexpan in which participants were asked to portray their personal experiences during the compulsory medical consultations of *Oportunidades*.

*Paula: I'll tell you what I felt during an appointment. Imagine that as soon as the doctor arrives (at the consultation room) she tells me not to get close to her. She tells me, 'Ma'am, move over there'.*

*Brenda: Yes, she doesn't want you to get close.*

Researcher: Why do you think she doesn't want you to get close?

*Paula: Well, because maybe she thinks that we have something [inherently] contagious. (Others agree)*

*Researcher: And how does that make you feel? (Asks all)*

*Paula: We feel she is undermining us... as if I was worth nothing to her.*

*Uma: One feels like . . .*

*Bere: (Interrupts) Like you are worth nothing. (Uma: Yes)*

*Ana: It affects your self-esteem!*

*Paty: It's like if she feels very tall and we are very small.*

*Paula: I thought so because that is how she said it, 'no, move, don't get close'. And I am sitting there thinking, 'The town worked for this? For [her] to be lazy and arrogant? (Many laugh) So [she] can talk to me any way [she] want[s] and treat us like that? No, that is not fair'. But I am not saying it aloud, only in my head.*

Researcher: Why don't you say it aloud?

*Elena: Because of fear. (Others agree)*

*Bere: As I was saying, she (doctor) tells us, 'If I want I can erase you from here and you will be out (from Oportunidades) quickly!' And that's it. She might even say, 'I will not sign your attendance record'. (Many agree)*

Focus group, Nexpan (R48)

This powerful conversation between recipients of *Oportunidades* captures a shared experience of a relationship based on power, devaluation and discrimination that influences a number of wellbeing domains. It demonstrates the feelings of powerlessness of recipients as they realise the control officers have over the resources they can have (material wellbeing) and how they feel and think about what they can do and be (subjective wellbeing). The officers are the direct gatekeepers of their cash transfer and the knowledge they receive from *Oportunidades* workshops.

In the way officers treat recipients, they are also mediators of more personal and subjective aspects of wellbeing such as the recipients' sense of competence and self-worth and their ability to use their agency.

Finally, as it was mentioned before, recipients were also wary that the quality of their relationship with officers had an impact on the quality and effectiveness of the medical attention received. This has been widely heard in the public health system in Mexico, not only in relation to *Oportunidades* but also in relation to obstetric care in general (Smith-Oka 2009, 2012, 2014, 2015). In recent years, numerous cases of women giving birth outside hospitals or who lose a child or their own lives because of the negligence of doctors have been published in newspapers (see e.g. Proceso 2016). This was mentioned a few times in Cualcan by women who themselves lost their babies because they did not receive timely medical attention due to the carelessness (as they perceive it) of the medical staff, many of which are part of the implementation of *Oportunidades*. A recipient in Nexpan had a similar experience just a week before our interview. After seeking care at the local clinic for weakness and other symptoms numerous times, a private physician detected she had severe anaemia (in women, anaemia is diagnosed when the levels of haemoglobin are less than 12.0 gram/100 ml. Laura had 2.8 grams/100ml) when seven months pregnant. The doctors in the *Oportunidades* clinic dismissed her symptoms several times.

> (Researcher: Just to conclude this interview, could you please share with me what is important for you to live well?) *Well, after what just happened, for me the first thing is health. Yes, because if we do not have health we cannot do anything else. Having health does not mean that we want [doctors and nurses] to send us flowers, having health is that they give us a good care.* (Researcher: What do you mean by a good care?) *As I was telling you, sometimes they do not even touch you, or ask, 'what do you feel here or there?' 'Explain to me what you are feeling'. No! They only kind of look at you and kind of listen to you and just like that they write a prescription. What I mean by good care is that they explore you well, that they listen to you, that they listen carefully to what you are feeling. When I am at a consultation, I want to be able to explain well where it hurts and what am I feeling. Also, they need to talk to you appropriately. That is enough. They usually talk harshly, they not even look at you, and even diminish how you feel. 'No, these are only symptoms of your pregnancy, you are just exaggerating!' (…) So this is why I think that Oportunidades needs to pay attention to everything, is not enough to send staff or give money away, they need to look at the kind treatment [that is provided] and the extortions that*

> *lie behind it. Even the private doctor said that she could identify [my anaemia] by my pale countenance and they (Oportunidades health officers) made me think it was all in my head! So I think, if they are educated, why didn't they see it before? Why didn't they stop for just a moment? What is the need that someone is lost (dies), that a family is lost because of this? Because God forbids, but if I die, my children will not be well. Who will care for my baby? So it is not about undertaking a quasi-medical revision but about doing a proper revision. Doctors should also receive workshops about how to treat people.* Luisa, recipient, Nexpan (R49)

While this is a compelling quote on the importance of health and appropriate medical care for wellbeing, this quote convincingly depicts that in this context being healthy is not only something that you have or don't have, being healthy is something that is highly mediated by the relationship with health officers and the quality of the treatment and care received. This quote is also offering a powerful statement about the centrality of paying attention to the relationships that are created during policy delivery and their effects on subjective, material and relational wellbeing.

## 6.5 Conclusion

The aim of this chapter was to understand the perspectives of recipients about their relationship with the officers that implement the health conditionalities of *Oportunidades* and their influence on what recipients 'think and feel about what they can do and be' (White et al. 2014).

The findings suggest that *Oportunidades* has multiple benefits on the wellbeing of recipients beyond the provision of the cash transfer. Indeed, for participants, *Oportunidades* is a programme that improves their economic confidence, health, sense of competence and self-worth, and social connectedness through both the cash transfer and the conditions that come attached to it. Yet, in the conversations about their experiences complying with the conditions of the programme, the central role of their interactions with health officers was unavoidable.

Having a good relationship with health officers was important to recipients based on two key roles of officers in the clinic: the provision of medical care and their policing of the health conditionalities. More importantly, however, recipients' evaluations of their relationship with officers often coupled the medical attention with their personal

relationship. Indeed, recipients valued more those officers with whom they had kind, open and empathic interactions than those who might have more medical proficiency but rough manners and attitudes. Their experiences suggested that the personal relationship and attitudes of health officers can indeed reduce the quality of the workshops and the medical attention provided.

The nature and quality of this relationship as experienced by recipients also varied between localities and health staff, confirming the differences found in chapter five between temporary and permanent staff. When a relationship was considered positive, recipients emphasised aspects such as respect, communication, empathy, and dedication. Yet, negative relationships were characterised as those that involved disengagement, mistreatment, verbal abuse, personal or public humiliation, abuse of power and discrimination.

The most important finding of this qualitative study was associated with the breath and strength in the role of negative relationships with *Oportunidades* officials on the wellbeing of recipients. Whereas there were also indications that positive relationships were significant for wellbeing, recipients did not underline these as intensely as they did when interactions were negative. This could be because negative experiences are more consequential and meaningful for people than positive experiences. Finally, the qualitative findings also uncovered the dynamic and ambiguous nature of officer-recipient relationships, which make it difficult to classify a relationship as ultimately positive or negative and which are dependent on the level of empowerment and assertiveness, and the negotiation capacity of the actors involved. Nonetheless, the overall results suggest that the nature of the relationship between recipients and officers and how it unfolds has the potential of mediating the wellbeing of recipients in distinct domains. Following the IWB approach, the domains that were more frequently mentioned in the recipients' accounts were economic confidence, agency and participation, competence and self-worth and health.

# 7. The indicators: The Quality of the Relationship with Officers (QoR) and Inner Wellbeing (IWB)

# 7.1 Introduction

The quantitative study of this dissertation is presented in this chapter and in chapter eight. It seeks to answer the research questions of this study concerning the quality of the officer-recipient relationships in *Oportunidades*, the wellbeing of recipients and their association in the two localities of this study.

The quantitative analysis went through a five-step procedure that sets the basis of the structure of this chapter and chapter eight. This chapter presents step one and two. Section 7.2 presents step one in which the sample, the data set collected in each locality, and the key instruments used for this study are inspected and described. Section 7.3 presents step two, which covered the construction of the Inner Wellbeing (IWB) domains and the Quality of the Relationship with Officers scale (QoR) through factor analytic procedures. During the presentation of these initial analyses, the chapter engages in a discussion about their conceptual and methodological implications for the study of wellbeing and relationships and for undertaking a mixed-methods study.

# 7.2 Methods

## 7.2.1 Participants

In total three hundred and twelve (n = 312) participants completed the surveys, 142 in Cualcan and 170 in Nexpan. Table 7.1 shows the distribution of the sample by different socio-demographic categories. As mentioned in the methodology, because the target population of *Oportunidades* is mainly mothers, the sample is mostly composed of female recipients, accounting for 96.2% of the sample (only 12 (3.8%) men completed the survey).

The sample's distribution in terms of ethnicity was almost completely determined by the locality since in Cualcan 97.9% of participants self-identified as speaking an indigenous language compared to only 5.3% in Nexpan. Similarly, approximately 80% of the sample in each locality, reported being married or living with a partner, whereas the rest were widows, divorced or never married.

In relation to the participants' association with *Oportunidades*, 64.7% of all participants reported only acting as recipients in the programme, whereas 35.3%

reported having performed or currently performing other roles such as being a *vocal* or part of the health committee in the local clinic. This proportion was however different in each locality, with 18.3% of Cualcan's and 49.4% of Nexpan's recipients taking part as either role. The difference in the proportion among localities might be primarily caused by the process of selection and rotation of the health committee members. In Cualcan this process is based on voluntary participation whereas in Nexpan the rotation is conducted every year based on the list of recipients ordered by surname. The logical result is that in Nexpan more recipients have performed this role than in Cualcan[60].

**Table 7.1** Demographics

| | | Total Sample | | Cualcan | | Nexpan | |
|---|---|---|---|---|---|---|---|
| | | N | Percent | N | Percent | N | Percent |
| Gender | Female | 300 | 96.2% | 136 | 4.2% | 164 | 96.5% |
| | Male | 12 | 3.8% | 6 | 95.8% | 6 | 3.5% |
| Ethnicity | Indigenous | 148 | 47.4% | 139 | 97.9% | 9 | 5.3% |
| | Non-Indigenous | 164 | 52.6% | 3 | 2.1% | 161 | 94.7% |
| Marital Status | With Partner | 245 | 78.5% | 113 | 79.6% | 132 | 77.6% |
| | Without Partner | 67 | 21.5% | 29 | 20.4% | 38 | 22.4% |
| Role in Oportu-nidades | Recipient | 202 | 64.7% | 116 | 81.7% | 86 | 50.6% |
| | Vocal or Health Committee member | 110 | 35.3% | 26 | 18.3% | 84 | 49.4% |

## 7.2.2 Measures

Chapter four explained in detail the three key scales of wellbeing and quality of relationships with officers that are the basis of the quantitative analysis of this dissertation (see section 4.5.3.1 and appendix E for survey). To recapitulate, the psychosocial model of Inner Wellbeing (IWB) was the main scale used to assess wellbeing. This model is originally comprised of seven domains and measured through 36 items presented in table 7.2. To measure global wellbeing, the well-known indicators of SWB, happiness and life satisfaction, were employed. Finally, the Quality of Relationships with Officers scale (QoR) developed from the qualitative analysis comprises 14 items presented in table 7.3[61].

[60] As explained in chapter three, since *vocales* and health committee members spend more time at the clinic, it is expected that these roles are significant for the terms of the relationship with officers and their influence on wellbeing. This is explored in chapter eight.
[61] The stars on the item names in both tables indicate that these are reversed coded questions.

**Table 7.2** Inner Wellbeing Indicators

| Item | Question |
|---|---|
| EC1 | How do you feel about your economic situation? |
| EC2 | How well could you manage economically if something wrong were to happen (e.g. illness in the family)? |
| EC3* | To what extent your economic worries affect your participation in the town celebrations? |
| EC4* | Do you feel that people around have done better economically than you? |
| EC5* | How often do you feel worried about money? |
| AP1 | In a town meeting, do you feel that you can give your opinion freely? |
| AP2 | If an authority makes a decision that affects you directly, do you feel that you can protest against it? |
| AP3* | How often do you feel others do not care about what you have to say? |
| AP4 | How often can you and your town unite to do something together in favour of your community? |
| AP5 | How often do you feel that you have the freedom to make your own decisions? |
| SC1 | If you need something (find a job, talk to an authority) do you have any friends or people you know that knows how to help you? |
| SC2 | Do you feel that you have friends or acquaintances in which you can count on during difficult times? |
| SC3 | How often do you feel included in your community? |
| SC4 | In general, do you feel that people in your community are helpful? |
| SC5* | To what extent you feel affected by gossip or what your neighbours and people in your community could say about you? |
| CR1 | When you need to talk about something that is important to you, is there someone you can go to? |
| CR2 | How often do you feel there is harmony in your home? |
| CR3 | Do you feel that your family cares about you? |
| CR4 | In general, how often do you feel that your family supports you in the important decisions you make? |
| CR5* | How worried are you about the amount of violence in your home? |
| CR6 | In general, do you like the way that your family treats you? |
| PMH1 | How often do you sleep well? |
| PMH2* | How often do you feel tense or worried? |
| PMH3* | How often do you feel sad? |
| PMH4 | How often do you feel that you have the strength you need for your daily work? |
| PMH5* | In the last months, how much have you worried about your health? |
| CSW1 | How capable do you feel of helping others? |
| CSW2 | In general, how capable do you feel of achieving the things that matter to you? |
| CSW3 | In general, how good do you feel you are in performing your daily tasks? |
| CSW4* | How often do people around you make you feel that you are not capable of doing or saying things? |
| CSW5* | How often do you feel as if you were ignorant? |
| VM1 | Do you feel that life has been good to you? |
| VM2 | Do you feel that God is with you? |
| VM3 | How often do you feel that your life has been worthwhile? |

**Table 7.3** QoR Indicators

| Item | Question |
|---|---|
| qor1 | Do you feel that the way you are asked to comply with the conditions of the programme is appropriate? |
| qor2 | Thinking about your experience in general, do you feel that the doctor/nurses pay attention to you? |
| qor3 | Do you feel that the doctor/nurses treat you with kindness and respect? |
| qor4 | When you go to the clinic to a consultation or workshop, do you feel that the doctor/nurses explain things appropriately? |
| qor5* | Do you feel the doctor/nurses in the clinic abuse of their position? |
| qor6 | When the doctor/nurses say or do something you do not like, do you feel that you can say or do something about it? |
| qor7* | Have you felt discriminated during your consultations or workshops in the clinic? |
| qor8* | Have you felt scolded by a doctor/nurse in front of others? |
| qor9* | Have you felt insulted or humiliated by a doctor or nurse in the clinic? |
| qor10* | Do you feel that everybody finds out about the reasons for your visit when you go to the clinic for a consultation? |
| qor11 | Do you feel that the waiting time you spend to get a medical consultation in the clinic is worth the while? |
| qor12 | When you go to the clinic, do you feel that you receive an adequate medical revision? |
| qor13 | Do you feel that the doctor and nurses try to give you the best attention? |
| qor14 | Do you feel that the doctor and nurses are sensitive to you and your needs? |

## 7.3 Construction of the main scales using Factor Analysis

Factor analytic procedures were used to construct and validate the IWB and QoR scales. Factor analysis has the objective of reducing a set of observed variables into a more manageable set of composite factors by assuming that they are linear combinations of an underlying factor that cannot be measured directly (Hair et al. 2010). This statistical procedure is deemed most appropriate for this research since it is used to develop theory and scales and to assess their construct validity.

In the broadest sense, the uses of factor analytic procedures can be divided into two. Exploratory Factor Analysis (EFA), as its name suggests, is used to explore the structure behind the data and to develop and evaluate scales. This procedure is recommended at early stages of scale development. Confirmatory Factor Analysis (CFA) on the other hand, is employed to test a hypothesis or an underlying theory, and is recommended when a scale has already been validated or when there are good theoretical grounds supporting an a priori hypothesis.

In recent years, however, there has been on-going debate regarding the conditions in which each procedure is preferred over the other. Within this debate, some advocate for a dialogue between EFA and CFA since both provide complementary pieces of information about the structure of the data: the EFA allows establishing the reliability and validity of the construct measurements of the models, whereas the CFA allows rigorous evaluation of their goodness-of-fit for this data. This is the position that this research is taking in the construction of both IWB and QoR scales for two reasons.

At a first look a CFA could be considered best to evaluate the IWB model since this model has strong theoretical grounds and has been successfully validated in other samples (White et al. 2014, Gaines 2014). Yet, the fact that this research and the IWB model itself gives especial importance to the context and its influence on the way people think and talk about wellbeing, some of the items were adapted to the two localities based on qualitative enquiry. Therefore, the procedure of contextualizing items justifies the use of an EFA as an initial statistical technique to explore the underlying patterns behind the data collected in the Mexican localities of Nexpan and Cualcan.

Conversely, the QoR scale has been particularly developed for this sample based on the qualitative study exploring the recipients' experiences with the medical staff. Therefore, despite being grounded on strong qualitative evidence, this scale still needs to be validated quantitatively and thus an EFA is ideal.

As a result, this research conducts both EFA and CFA to validate the IWB and QoR scales for this sample. These procedures and the results are presented next.

### 7.3.1 The IWB scale

The IWB model has been tested and validated in two contexts, India (White et al. 2014) and Zambia (Gaines 2014), obtaining positive results in terms of construct validity and model fit for a 7-domain model. To examine the extent to which these domains emerge for this sample or if new domains are more appropriate, Exploratory Factor Analysis (EFA) and Confirmatory Factor Analysis (CFA) were conducted using SPSS 22 and AMOS.

#### 7.3.1.1 Data screening

Prior to the EFA, and to ensure quality of data, the dataset was cleaned up through procedures that inspected for issues that particularly affect ordinal scales such as non-engaged responses[62], missing values, and variables with severe kurtosis. The analysis of non-engaged responses and missing values suggested that all responses were complete and operational. On the other hand, the tests for kurtosis revealed that one item of the Values and Meaning domain (VM2) suffered from severe kurtosis with a value greater than 2.0 (3.979).

Kurtosis happens when many values of an item lie in the same place (for example, most people answer 5), causing not enough variance in the item to reliably predict any changes on it. Therefore, it is advised to eliminate it from the analysis. The VM2 item asked respondents about the degree to which they felt that God was with them. In the context in which this survey was applied, all except one respondent reported being a religious person and accordingly, the majority of participants answered 5 (very much) to the VM2 item. Four other items (EC3, SC5, CR5, and PMH5) suffered from minor kurtosis and were eliminated only after conducting further analysis that confirmed their problematic effects in the EFA.

The lack of agreement on the minimum sample size to conduct a factor analysis is well noted in the literature (see Hair et al. 2010). Two rules of thumb indicate that having 5 or 10 participants for every variable in the model is appropriate (ibid). Based on these general rules, the power calculation for this data set indicated that the sample size of 312 participants is appropriate for conducting a factor analysis on the 36 items of the IWB model.

The Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy supported the decision of conducting a factor analysis with this data, offering a value of 0.798 greater than the commonly accepted threshold of 0.7 (Field 2013). Similarly, Bartlett's Test of sphericity was statistically significant ($p<0.0005$) which corroborates that the data is suitable for factor analytic procedures. The table of communalities also indicated that most factors had values greater than 0.5, which signal that the extracted factors explain most of the variance in the variables being analysed.

[62] Non-engaged responses is an issue specific to survey questions that happens when respondents are not answering the survey based on their own experiences but simply in an automatic or mechanical manner.

After conducting the EFA additional variables were dropped from the analysis due to poor loading (less than 0.35) in any factor, or loading on two or more factors at a time (with values of 0.35 or higher). For example, the item of AP5 cross-loaded with items belonging to the Social Connections factor. AP5 asked, “How often do you feel that you have the freedom to make your own decisions?” AP5 can be interpreted as tapping a relational aspect of agency since one’s freedom of choice can be evaluated based on one’s relationships to others. Therefore, it could be argued that this relational nature of the item is behind the cross-loading observed with the domain of Social Connections. The literature advises that when one item loads in two factors at a time it is a signal that the item does not clearly reflect one particular aspect of wellbeing. In other words, the meaning of the item is ambiguous and so it is advisable to drop it from the model. This is indeed an unavoidable limitation of quantitative methods.

#### 7.3.1.2 Results from the Exploratory Factor Analysis (EFA)

The final solution of an unconstrained EFA procedure using Principal Components (PC) as the extraction method[63] and Promax as the rotation method[64], revealed an eight-factor solution with eigenvalues greater than 1 and yielding a Total Variance Explained of 56.85%[65]. Table 7.4 below shows the pattern matrix of item loadings, the total variance explained by each factor and their reliability scores. As expected, all loadings were positive and significant using the 0.350 threshold recommended by Hair et al. (2010) for sample sizes greater than 250. Similarly, the loadings within each factor average above 0.600 for all factors except for Factor 3 (SC), which is just at the margin with an average loading of 0.573.

One characteristic of this model is that two factors (Factor 6 and 8) are composed of only two items. This can be a limitation of the scale because factors with less than 3 items have the potential of increasing instability within the factors (Costello and Osborne 2005) and cause the model to be under-identified (Hair et al. 2010). Yet, the

[63] A variety of factor extraction models exist, such as the common factor approach or the components approach. This dissertation employed the Principal component analysis (PCA) approach since it reduces the number of variables by creating linear combinations which retains as much as possible of the variance in the original variables.
[64] A Promax rotation is appropriate since it assumes that the factors are correlated with each other. This is consistent with the theory behind the IWB model that postulates these domains as constituting one model of wellbeing between them.
[65] A regression method was used to calculate the factor score of each IWB domain extracted.

study of Guadagnoli and Velicer (1988, p.274) support the interpretation of these factors since the sample size is greater than 300 observations.

**Table 7.4** Factor analysis of the IWB model

| Items | Loading | | | | | | | | Commu-nalities |
|---|---|---|---|---|---|---|---|---|---|
| | F1 | F2 | F3 | F4 | F5 | F6 | F7 | F8 | |
| CR6 | 0.78 | | | | | | | | 0.60 |
| CR3 | 0.77 | | | | | | | | 0.60 |
| CR4 | 0.73 | | | | | | | | 0.54 |
| CR1 | 0.68 | | | | | | | | 0.59 |
| CR2 | 0.46 | | | | | | | | 0.45 |
| VM4 | | 0.77 | | | | | | | 0.61 |
| VM5 | | 0.74 | | | | | | | 0.64 |
| VM3 | | 0.72 | | | | | | | 0.58 |
| VM1 | | 0.41 | | | | | | | 0.43 |
| SC3 | | | 0.82 | | | | | | 0.58 |
| SC2 | | | 0.58 | | | | | | 0.61 |
| SC4 | | | 0.53 | | | | | | 0.45 |
| SC1 | | | 0.36 | | | | | | 0.42 |
| PMH2 | | | | 0.74 | | | | | 0.59 |
| PMH3 | | | | 0.70 | | | | | 0.57 |
| EC5 | | | | 0.55 | | | 0.41 | | 0.58 |
| PMH1 | | | | 0.44 | | | | | 0.43 |
| CSW2 | | | | | 0.72 | | | | 0.57 |
| CSW3 | | | | | 0.72 | | | | 0.63 |
| CSW1 | | | | | 0.66 | | | | 0.54 |
| AP2 | | | | | | 0.85 | | | 0.65 |
| AP1 | | | | | | 0.79 | | | 0.66 |
| EC2 | | | | | | | 0.81 | | 0.67 |
| EC1 | | | | | | | 0.68 | | 0.57 |
| EC4 | | | | | | | 0.43 | | 0.44 |
| CSW5 | | | | | | | | 0.80 | 0.68 |
| CSW4 | | | | | | | | 0.75 | 0.67 |
| Variance Explained | 19.6 | 7.74 | 7.03 | 5.21 | 4.99 | 4.35 | 4.21 | 3.72 | (56.85) |
| Reliability alpha | 0.74 | 0.72 | 0.60 | 0.60 | 0.57 | 0.57 | 0.47 | 0.58 | (0.875) |

Note: Figures given in parentheses are the total variance explained and the reliability coefficients for the whole IWB scale.
Extraction Method: Principal Component Analysis
Rotation Method: Promax

Given the disagreement in the literature, this research was presented with the dilemma of eliminating these factors or keeping them. The literature recommends at

least 3 items per factor to increase reliability estimates and generalizability. Nonetheless, factors 6 and 8 are capturing two aspects of wellbeing that during the qualitative analysis were found to be essential not only for wellbeing, but key domains through which relationships have a role on wellbeing: political participation and social recognition. The interpretations of the factors are presented in detail next.

As a result, it was decided to keep the factors with the acknowledgement that they are only capturing certain aspects of the complexity of the domains. Therefore, even though the characteristics of these factors might not be ideal according to some authors, they are still useful to explore the association between these aspects of wellbeing and the quality of people's relationships, which is the ultimate objective of this dissertation.

#### 7.3.1.3 Reliability

Cronbach's alpha was used as a measure of internal reliability for the scale as a whole and for each factor. This test of internal consistency shows the extent to which all items in each factor are measuring the same concept or construct by exploring their inter-correlations (Hair et al. 2010). Hair and colleagues (2010) suggest that a value of 0.60 is acceptable in exploratory research. For this sample, the IWB scale displayed excellent internal reliability on the total scale (α=0.88). Cronbach's alpha coefficients for each factor indicated good, moderate, and poor levels of internal consistency (see table 7.4). Factor 7 is particularly worrying due to a Cronbach's alpha value of 0.47. The literature warns, however, that this diagnostic is very sensitive to the number of items within each factor, decreasing with the number of items. Thus, having less than 4 items could cause the low value of alpha present in some of the factors.

In addition, some have questioned the strength of Cronbach's alpha as a measure of instrument reliability in heterogeneous scales (Konerding 2013). According to Konerding, heterogeneous scales are those that are composed of items that address qualitatively different aspects of the object under investigation. Under this definition, the IWB scale can be considered a heterogeneous scale since the items within each domain cover different aspects of the domain being measured.

For example, two items within Economic Confidence ask “How well could you manage economically if something bad were to happen?” and “Do you feel that people around you have done better economically than you?” In addition to having different wording, the first item evaluates the person’s economic confidence in a particular situation, such as an emergency or their economic capacity in the long run; whereas the second item captures people’s economic situation in relation to others around them. The fact that these items are measuring different aspects known to be relevant for economic wellbeing, arguably, causes the items to not correlate perfectly with each other[66].

As a result, according to Konerding (2013), this should not be interpreted as reflecting any issues of measurement error since the Cronbach’s alpha test presented here could be underestimating the true reliability of the IWB scale. Instead, the author recommends using the test-retest approach that involves re-applying the scale in the same locations and over a short period of time. Unfortunately, due to time and cost constraints this was not a possibility in this research project, but should be considered for future research.

#### 7.3.1.4 CFA and Model Fit

CFA is useful to confirm or reject with precision the structure of the model established during the EFA, a CFA was conducted in AMOS 22 through Maximum Likelihood estimation (see appendix G). A CFA helps evaluate how well the measured variables represent a smaller number of constructs found in the EFA (Hair et al. 2010). The most used parameters to evaluate model fit involve the $X^2$ goodness-of-fit statistic and fit indices.

Fit indices evaluate how well the proposed model accounts for the correlations between the observed variables in the data. Fit statistics like CFI evaluate the model’s *goodness of fit* that implies that the model is accounting for all major correlations in the data and that the model is plausible (Schermelleh-Engel et al. 2003). Conversely, the SRMR and RMSEA statistics evaluate the model’s *badness of fit*.

[66] This can be corroborated by the relatively low correlations between the IWB items shown in appendix F.

**Table 7.5** IWB Model Fit

| Statistic | Model | Ideal Threshold |
|---|---|---|
| CMIN/df | 1.625 | Between 1 and 5 |
| CFI | 0.883 | >0.90 |
| RMSEA | 0.045 | <0.07 |
| SRMR | 0.057 | <0.08 |

Overall, the goodness of fit indices for the final measurement model presented in table 7.5 suggest that all thresholds proposed by Hu and Bentler (1999) are met except for the CFI statistic that does not quite reach the ideal threshold. Nonetheless, some authors argue that a cut-off value > 0.80 is acceptable (Gaskin 2012)[67]. Hence, as suggested by Hu and Bentler (1999) if a combination of statistics indicates that the model is a good fit, then one can be confident about the goodness of fit of the IWB model for this data set.

#### 7.3.1.5 Interpreting the IWB factors

In interpreting the factors, the theoretical meaning of the items that loaded within each factor were checked and compared to the findings in earlier studies using the IWB scale (White et al. 2014, Gaines 2014, White and Ramírez 2015). The factor analytic procedures conducted for this sample found similar results to the previous studies. This section presents the factors found for this sample and interprets the results. The resulting factors and all items that compose them are listed in table 7.6 for a better appreciation of their format and wording.

The first factor that loads in the pattern matrix presented in table 7.4 clearly captures the domain of Close Relationships (CR hereafter) as all items proposed by the IWB approach load in this factor and relate to the quality of personal relationships that people enjoy. For example, the items evaluate the level of harmony within the home and feelings of support and care from family members. The fact that this is the first factor that loads in the pattern matrix also indicates that the quality of intimate and

[67] Only one adjustment was required to address issues indicated by the modification indices that increased slightly the goodness of fit of the model.

close relationships is a critical factor in the inner wellbeing of this sample, explaining for 19.59% of the variance in the model.

**Table 7.6** IWB factors and items

| | Item | Question |
|---|---|---|
| 1 | CR1 | When you need to talk about something important to you, is there someone you can go to? |
| | CR2 | How often do you feel there is harmony in your home? |
| | CR3 | Do you feel that your family cares about you? |
| | CR4 | In general, how often do you feel that your family supports you in the decisions that you make? |
| | CR6 | In general, do you like the way that your family treats you? |
| 2 | VM1 | Do you feel that life has been good to you? |
| | VM3 | How often do you feel that your life has been worth the while? |
| | VM4 | How often do you feel at peace with yourself at the end of the day? |
| | VM5 | How often do you feel that your life has a meaning? |
| 3 | SC1 | If you need something (find a job, talk to a local authority), do you have any friends or acquaintances that could help you? |
| | SC2 | Do you feel that you have friends or acquaintances in which you can count on during difficult times? |
| | SC3 | How often do you feel not included in your community? |
| | SC4 | In general, do you feel that people in your community are helpful? |
| 4 | PMH1 | How often do you sleep well? |
| | PMH2 | How often do you feel tense or worried? |
| | PMH3 | How often do you feel sad? |
| | EC5 | How often do you feel worried about money? |
| 5 | CSW1 | How capable you feel of helping others? |
| | CSW2 | In general, how capable do you feel in achieving things that matter to you? |
| | CSW3 | In general, how good you feel in achieving your daily tasks? |
| 6 | AP1 | In a town meeting, do you feel that you can give your opinion freely? |
| | AP2 | If an authority makes a decision that affects you directly, do you feel that you can protest against it? |
| 7 | EC1 | How do you feel about your economic situation? |
| | EC2 | How well could you manage economically if something wrong were to happen? |
| | EC4 | Do you feel that people around you have done better economically than you? |
| 8 | CSW4 | How often do people around you make you feel that you are not capable of doing or saying things? |
| | CSW5 | How often do you feel as if you were ignorant? |

Factor 2 is composed of the four items of the Values and Meaning (VM) domain. The items that loaded in this factor are related to a sense of meaning in life, such as feeling at peace with oneself and feeling that one's life has been worthwhile. It is important to recall that the VM2 item measuring the relevance of religion in people's lives had to be dropped from the analysis due to a high proportion of participants responding that they "always" felt God was with them. The fact that this item is missing from the scale suggests that Factor 2 is mostly picking up a general sense of a meaningful life,

without defining any source from which that sense of meaning could come from, as it would be if a question about religion is directly introduced. This domain could also be related to a general satisfaction-with-life measure[68], yet capturing less of the economic aspect of a meaningful life.

Factor 3 represents another relationship domain within the IWB model, Social Connections (SC). In this factor, 4 items of the initial theoretical construct are represented, capturing the quality of one's social environment and the level of connectedness to one's community. For example, the first two items convey the strength and quantity of one's ties to others, whereas the last two items tap on their perceived quality. White et al. (2014) suggest that this domain represents those less intimate and more political relationships that extensive research has shown to be important for wellbeing.

In this sample, the domain of Physical and Mental Health of the IWB model was not successfully measured, as it is evident from Factor 4. In this case, the latent construct captured in factor 4 is Mental Health (MH) since the common underlying theme of the items that load in it tap on feelings of worry, tension, stress, and sadness. It is worth noting that one item of the Economic Confidence domain consistently loaded in this factor, with only minor cross loading with the Economic Confidence domain itself. This could suggest two things. Firstly, that in this sample the sense of worry that the item is capturing, overrides the monetary aspect. And secondly, this could also suggest that one of the main sources of poor mental health in this sample was their poverty and the risks behind being poor that has been consistently underlined by research on mental health and poverty (e.g. Lund et al. 2010, Hanandita and Tampubolon 2014).

Two of the items of the original PMH domain were intended to measure physical health[69]. However, in this sample these items showed problems of negative loading (PMH5) and cross-loading (PMH4) that indicated that they should be eliminated from the analysis. There are two possible reasons behind these problems. In the case of PMH5, during the final application of the survey it was noticed that this item prompted most participants to give extreme answers (usually a score of 1 or "A great deal").

[68] Chapter eight analyses the statistical association between IWB domains and SWB indicators, finding that life satisfaction holds a correlation of 0.35 with the VM domain.
[69] These items asked: "How often do you feel that you have the strength you need for your daily work?" (PMH4) "In the last months, how much have you worried about your health?" (PMH5)

Noticing this reaction during the fieldwork allowed me to explore some of the reasons participants had for providing such low scores.

The exploratory exercise suggested that many interpreted the question not as an evaluation of their overall health condition, but as the overall importance of their health for their wellbeing. For example, many of the participants expressed that though they were feeling healthy at present, their reasons for being “greatly” worried about their health was their fear of what would be the fate of their family (especially their children) in the event of getting ill. Even though this caused a problem in terms of factor analysis, it is interesting in its own right as it shows the relational roots of the relevance of wellbeing domains from people’s perspectives. That is, health is considered important not only for oneself but for others’ wellbeing. It also suggests that more concrete wording would have allowed a better assessment of people’s sense of health.

A similar issue was found with the PMH4 item during the EFA analysis, which showed cross-loading with the Competence domain. After further reflection, it is possible to conclude that the wording of the question as “feeling to have the strength to do your daily work” was related to a sense of ability rather than a sense of mental or physical strength. Finally, PMH5 and PMH4 never loaded with the other three items of the domain. This could also suggest that the Physical and Mental Health domain of the IWB model possibly constitutes two separate domains rather than one, yet further research is necessary to explore these nuances in the IWB model.

If we continue with the interpretation of the factors in the EFA output, the domain of Competence and Self-worth also took a different form in this research setting from what was expected from the IWB model. The domain was divided into two factors, 5 and 8. Factor 5 includes three items that capture people’s sense of being capable of helping others or achieving daily or more significant tasks or goals. The remaining two items that loaded in Factor 8 assess feelings of being able to say or do things or feeling ignorant. Despite having the theoretical expectation that these two factors would load together, this was not possible for this sample possibly due to some changes in the item wording as a result of the process of contextualization.

The latent constructs behind these two factors seem to tap in different aspects of wellbeing. Factor 5 clearly captures people’s personal feelings of being capable of doing or achieving, for this reason this factor retains the original name of the IWB domain of “Competence and Self-worth” (CSW). On the other hand, factor 8 alludes

to more social aspects of the self, such as feelings of adequacy that are derived from other's reactions towards one-self or perceptions of how one is recognised by others. Therefore, the domain is labelled as "Social Recognition" (SR).

Factor 6 of the EFA pattern matrix is composed of two items of the original domain in the IWB model called Agency and Participation. The two items that loaded in this factor capture people's ability to participate or express their opinion in their communities, particularly to a local authority or in a town meeting. Three items of the original domain were eliminated from the analysis due to kurtosis (AP3), and cross-loading with the domain of Social Connections (AP4 and AP5).

As mentioned earlier, one explanation of the cross-loading with the SC domain is the item wording that tapped into a relational experience of agency. For example, item AP4 asked, "How often do you feel that your town can get together to generate a positive outcome for your community?" Wording this question at a collective level rather than at an individual level could have increased its connection to other social domains in the model such as SC. As a result of this cross-loading, it was decided that these items should be dropped from the analysis.

This issue, however, points toward the difficulty that this type of statistical analysis has to separate aspects of wellbeing such as agency and participation that are embedded in relationships to other aspects that measure relationships directly (Social Connections). In other words, domains such as agency and participation are clearly aspects of wellbeing that are construed in relationship. Hence, if measured, the questions need to contain some form of relational wording or a relational essence into them that statistical tools such as Factor Analysis find difficult to discriminate. Another possible problem is that participants can interpret differently items that combine constructs such as agency in a relational context. Some might focus on the relational aspect while others focus on the agency aspect of the question. This results in a measure of agency that is not robust enough according to statistical norms.

Nonetheless, the items AP1 and AP2 were the strongest of the domain, alluding to people's sense of being able to voice their opinion and participate in social contexts such as a town meeting or in interactions with local authorities. Since these items are tapping on a particular experience of agency, it cannot be claimed that this factor is capturing a comprehensive understanding of the concept of Agency. For this reason, the domain does not retain the label used by the Wellbeing Pathways project and is changed to 'Political Participation' (PP hereafter). It is deemed valuable to retain this

domain for future analysis since this dissertation is interested in understanding the role of the quality of relationships with front-line officers who can be considered authorities in these localities.

Finally Factor 7 represents the domain of Economic Confidence (EC) composed of three of the original items of the domain. These items capture people's feelings about their economic situation overall and relative to others, and how well they feel they can manage economically.

#### 7.3.1.6 Discussion of findings and suggestions for future research

In sum, the findings gathered from the factor analytic procedures suggest that the structure of Inner Wellbeing of the recipients in these two localities of Mexico broadly resembles what was theoretically expected from previous studies that validated the IWB model in Zambia and India. Some of the reasons why the IWB of these recipients is not identical to the original IWB model could be the result of measurement matters. On the one hand, some of the items of this IWB survey were contextualized to these localities and thus differ from the original items in the IWB model. The contextualization of items to be more in-line with a language that was familiar to participants could have caused these discrepancies. On the other hand, based on statistical criteria such as excess kurtosis, other questions did not work well in this sample and had to be dropped from the analysis (e.g. items PMH4 and PMH5 measuring physical health in the PMH domain of the IWB model). Other possible reasons for the differences between the original IWB model and the domains found in this study could be a variability in the interpretation of the translated questions and cultural differences in the understanding of wellbeing itself.

The psychometric analysis however, showed that the IWB domains can be used for the objectives of this dissertation despite its limitations in terms of item-per-construct ratio and reliability scores in the domains of Economic Confidence, Political Participation (PP) and Social recognition (SR). Indeed, the CFA confirmed that this model fits the data and can be used to evaluate the wellbeing of this sample. Ultimately, the aim of this research is not to obtain a model of wellbeing that can be universalised or applied across contexts. Rather, the objective is to obtain a model that captures or approximates what wellbeing is and how it is experienced in these localities.

It is important to note, nonetheless, that the aforementioned psychometric limitations do warn that the inferences made with these factors in subsequent analysis should be taken with caution and further research is necessary to understand better the causes of these limitations. In the meantime, the results of this factor analysis already have important lessons about conducting empirical research on wellbeing, especially those that advocate the value of combining qualitative and quantitative methodologies and the contextualization of measures.

Firstly, the cross-loading found between some of the IWB items could be the result of the aim of this model of capturing those relational experiences of wellbeing that were consistently found in the qualitative analysis of this dissertation but also in the qualitative studies of wellbeing reviewed in chapter two. As is commonly argued in the literature discussing 'best' survey practices, to measure a construct successfully it is important that the question wording is specific enough. This is to ensure that each variable measures only one construct and not several at a time (Sudman and Bradburn 1982, Fowler 1995).

Common statistical techniques used to understand the relationships between variables greatly depend on an analysis of how the item varies across people and in relation to other items. And if two or more constructs are tapped within one measure, the process of identifying that variability within the measure becomes more complex. As a result, the statistical tests currently used to study wellbeing require the simplification and compartmentalization of this complex and interrelated experience into questions that clearly tap one aspect of wellbeing and do so at the individual and not the relational level.

Secondly, techniques such as factor analysis also showed limitations to interpret heterogeneous models such as IWB. Factor analysis depends on the correlation or covariance between variables to infer the underlying constructs that they are measuring. The fact that the domains of the IWB model attempts to capture different aspects of each domain of wellbeing, reduces the size of the correlation between items that qualitatively have been validated to belong to that domain. Other techniques such as structural equation modelling and item response theory models (e.g. Van Schuur 2011) have been recommended for this type of model and indicators and they should be considered and evaluated in further research.

Ultimately, these tensions between the quantitative and qualitative methodologies in the study of social phenomena, and the clash between the validation of measures

using each technique, raises potentially bigger questions about the exclusive reliance on this type of statistical techniques to validate measures of complex social phenomena like wellbeing. Certainly, measures can only provide an approximation to the lived experience of wellbeing, yet, we still need further research to try to bring these two methodological tools closer together, especially if the use of mixed-methodologies becomes increasingly popular (and necessary).

### 7.3.2 The QoR scale

To fully explore the role of the relationship with front-line officers in the wellbeing of the recipients of *Oportunidades*, a section of the survey evaluated through 14 questions the subjective perceptions of the quality of this relationship. The following sections present the factor analytical procedures used to construct the scale and the interpretation of the latent constructs in the data.

#### 7.3.2.1 Data screening

The same procedure as in the case of IWB was conducted to ensure the quality of the dataset, exploring for non-engaged responses, missing values, and skewness and kurtosis. None of the QoR items suffered from skewness or severe kurtosis (values greater than 2.2) and only a few suffered from kurtosis in the strict sense (values greater than 1). Yet, following Sposito's et al. (1983) suggestion that this level of kurtosis is not dangerous for statistical analysis with ordinal variables, these items were not eliminated from the analysis (cited in Gaskin 2012). Similarly, after exploring for missing values, it was concluded that the whole sample (n=312) could be used in the analysis of the QoR scale.

#### 7.3.2.2 Results from the EFA

The initial analysis comprised an unconstrained EFA procedure conducted in SPSS using Principal Component Analysis as the extraction method and Promax as the rotation method. The initial analysis suggested that items qor5 and qor6 failed to load only in one factor, causing cross-loadings in the model. In addition, items qor1, qor6, and qor11 showed low communality scores. Communality reflects the amount of

variance that one variable shares with all other variables included in the analysis. Hence, if a variable shows a low communality this indicates that it is not explaining enough the underlying construct in the data and therefore should be omitted from the analysis. After exploring for any other issues of cross-loading and low loadings, the model that explained the data best is the two-factor model presented in table 7.7.

**Table 7.7** Factor analysis of QoR scale

| Items | Loading | | Communalities |
|---|---|---|---|
| | Factor 1 | Factor 2 | |
| qor2 | .771 | | .639 |
| qor3 | .625 | | .684 |
| qor4 | .713 | | .576 |
| qor7 | | .632 | .612 |
| qor8 | | .942 | .764 |
| qor9 | | .894 | .769 |
| qor12 | .833 | | .641 |
| qor13 | .878 | | .732 |
| qor14 | .853 | | .624 |
| Variance Explained | 54.6% | 12.5% | (67.1%) |
| Reliability Alpha | 0.89 | 0.79 | (0.89) |

Note: Figures given in parentheses are scores for the QoR scale as a whole.
Extraction Method: Principal Component Analysis
Rotation Method: Promax

In the inspection of the sampling adequacy of the data, the Kaiser-Meyer Olkin (KMO) measure suggested that the sample was factorable (KMO=0.906). The two-factor model shown in table 7.7 depicts a very clean structure and a strong convergent and discriminant validity through high loadings within factors and no cross-loadings using the 0.200 threshold accepted in the literature (Matsunaga 2010). All loadings were significant and above the 0.350 threshold for samples greater than 250 (Hair et al. 2010). Similarly, both factors have excellent average loadings of 0.779 and 0.823 respectively. Finally, the Total Variance Explained of this model was very good (67.142%).

### 7.3.2.3 Reliability

The reliability of the scale measured by the Cronbach's alpha coefficient confirms that the QoR model has excellent levels of internal consistency based on the threshold

value of 0.6 or greater proposed by Hair and colleagues (2010). As shown in table 7.7, the QoR scale as a whole obtained an alpha value of 0.89, whereas Factor 1 and Factor 2 obtained scores of 0.89 and 0.79 respectively. These scores are well above the minimum threshold, indicating that the QoR scale is a reliable measure according to the Chronbach's alpha reliability test.

#### 7.3.2.4 CFA and Model Fit

In terms of model fit, the CFA confirmed the factor structure of the previous exploratory analysis, as well as the validity and reliability of the model (see appendix H for the model constructed in Amos through Maximum Likelihood estimation). The goodness of fit statistics of the final measurement model is shown in table 7.8. They confirm that all thresholds are met based on Hu and Bentler (1999) and Hair et al. (2010).

**Table 7.8** QoR Model Fit

| Statistic | Model | Ideal Threshold |
|---|---|---|
| CMIN/df | 3.323 | Between 1 and 5 |
| CFI | 0.956 | >0.90 |
| SRMR | 0.048 | <0.08 |

To obtain adequate goodness of fit, this model did not require further adjustments based on the modification indices. As a result, we can conclude that this is a very satisfactory model to measure quality of relationships with the medical staff in these two localities in Mexico.

#### 7.3.2.5 Interpreting the QoR factors

Unlike the seven themes that emerged from the qualitative data describing the quality of the relationship with the officers, the quantitative analysis suggested that these themes are in fact reflecting two underlying constructs.

On the one hand, the items that load onto the first factor clearly relate to a positive evaluation of the quality of this relationship. Indeed, as shown in table 7.9, items qor2

to qor4 and qor12 to qor14 are strictly positively phrased questions. For instance, qor3 asks, “Do you feel that the doctor/nurses treat you with kindness and respect?” While item qor13 examines “Do you feel that the doctor and nurses try to give you the best attention?”

**Table 7.9** QoR factors and items

| Item | Question | Theme (Qualitative) | |
|---|---|---|---|
| qor2 | Thinking about your experience in general, do you feel that the doctor/nurses pay attention to you? | Communication | Positive Relationship |
| qor3 | Do you feel that the doctor/nurses treat you with kindness and respect? | Respect | |
| qor4 | When you go to the clinic to a consultation or workshop, do you feel that the doctor/nurses explain things appropriately? | Communication | |
| qor12 | When you go to the clinic, do you feel that you receive an adequate medical revision? | Dedication / Care | |
| qor13 | Do you feel that the doctors and nurses try to give you the best attention? | Dedication / Care | |
| qor14 | Do you feel that the doctors and nurses are sensitive to you and your needs? | Dedication / Care | |
| qor7* | Have you felt discriminated during your medical consultations or workshops in the clinic? | Discrimination | Negative Relationship |
| qor8* | Have you felt scolded by a doctor/nurse in front of others? | Humiliation | |
| qor9* | Have you felt insulted or humiliated by a doctor or nurse in the clinic? | Humiliation | |
| qor1 | Do you feel that the way you are asked to comply with the conditions of Oportunidades by doctors/nurses is appropriate? | Abuse of power | Excluded indicators |
| qor5* | Do you feel that the doctors/nurses abuse of their position? | Abuse of power | |
| qor6 | When the doctor/nurses say or do something you do not like, do you feel that you can say or do something about it? | Communication | |
| qor10* | Do you feel that your privacy is respected by doctors/nurses in the clinic? | Confidentiality | |
| qor11 | Do you feel that the waiting time you spend to get a medical consultation is worth the while? | Time issues | |

On the other hand, all items that load onto the second factor are negatively phrased and thus relate to negative aspects of the relationship. Item qor7 captures issues of

discrimination and items qor8 and qor9 of humiliation[70]. As a result of this clear duality in the evaluation of the relationship with officers, the factors were labelled as Positive Quality of the Relationship (PveQoR) and Negative Quality of the Relationship (NveQoR) respectively.

It is interesting to note that most of the items that were eliminated from the analysis reflect issues that might not be directly related to the quality of the relationship itself but rather issues that lie on the periphery. For instance, qor6 could be tapping the recipients' sense of agency, rather than on the quality of the interaction that they have with officers. Similarly, qor11 captures the waiting time experienced when attending the clinic, which might not be something directly related to interactions with officers. Furthermore, one commonality of these items is that they have a more neutral wording, while the rest of the questions have a clear negative or positive phrasing about the quality of the relationship. In other words, they relate less to the personal interaction with the officer than they do to organisational procedures within the clinic. However, as it is discussed next, the results of this factor analysis could also be associated with the way people respond to questions that are positively, negatively and neutrally phrased.

#### 7.3.2.6 Discussion of findings and implications for future research

The exploratory and confirmatory factor analytic procedures arrive to a two-factor solution for the QoR scale that shows excellent internal consistency and model fit. It is therefore confirmed that this scale is a valid and reliable measure to assess the relationship between officers and recipients of the *Oportunidades* programme in the two localities of this research. This scale, however, is composed of two factors that measure positive and negative aspects of the relationship separately. These results could have two implications for our understanding of relationships themselves and the parts they play in the experience of wellbeing.

The first one leads to a reflection about our conceptual understanding of relationships. A similar duality to PveQoR and NveQoR is reported within the wellbeing literature not for relationships themselves but in the case of affective states or self-reported

[70] It is important to remind the reader that the wording of the items of the QoR scale was derived from the language used by the participants themselves during the focus groups and personal interviews conducted and analysed to construct the items.

mood. Since the 1960s (e.g. Bradburn 1969) research consistently found two dimensions of affect - positive (PA) and negative (NA) - from which the PANAS scale was developed (Watson et al. 1988). These two dimensions of affect are known not to correlate to the same types of variables, such as personality traits and emotional reactions. For example, research found that positive affect – but not negative affect – is related to social activity. Alternatively, negative affect – but not positive affect – is associated with stress. The theoretical thinking behind PA and NA, suggests that they are measuring qualitatively different affective states between the two factors, therefore they are theorised to be uncorrelated to each other[71] – i.e. they can move in different directions within the same person. For instance, a person can experience both high positive affect and high negative affect at the same time.

The extent to which the two indicators of the QoR scale are measuring unrelated features of a relationship or opposite sides within a continuum (e.g. humiliation on one side, and respect on the other) is unclear however. One indication that PveQoR and NveQoR are not isolated aspects of relationships is the moderate correlations found between all QoR items (table 7.10), although further research is necessary[72]. This is additionally supported by the qualitative findings of this dissertation (chapter six) that indicated that both positive and negative characteristics could coexist within one relationship (for example depending on the mood of the officer, the actors involved in the interaction, etc.). Indeed, relationships can be both respectful and humiliating at different moments.

**Table 7.10** Correlations between QoR items

| | q2 | q3 | q4 | q12 | q13 | q14 | q7 | q8 | q9 |
|---|---|---|---|---|---|---|---|---|---|
| q2 | 1 | | | | | | | | |
| q3 | .653** | 1 | | | | | | | |
| q4 | .573** | .587** | 1 | | | | | | |
| q12 | .518** | .525** | .525** | 1 | | | | | |
| q13 | .584** | .606** | .557** | .680** | 1 | | | | |
| q14 | .538** | .535** | .460** | .543** | .620** | 1 | | | |
| q7 | -.455** | -.555** | -.425** | -.429** | -.474** | -.405** | 1 | | |
| q8 | -.334** | -.448** | -.343** | -.366** | -.363** | -.276** | .508** | 1 | |
| q9 | -.420** | -.524** | -.410** | -.336** | -.394** | -.354** | .542** | .641** | 1 |

Pearson correlations (2-tailed), ** $p < 0.01$

[71] This is reflected on the use of varimax as a rotation method in the factor analysis. Varimax is a method that assumes that the factors are uncorrelated to each other. Therefore, the factors extracted from this analysis have zero correlation between them.

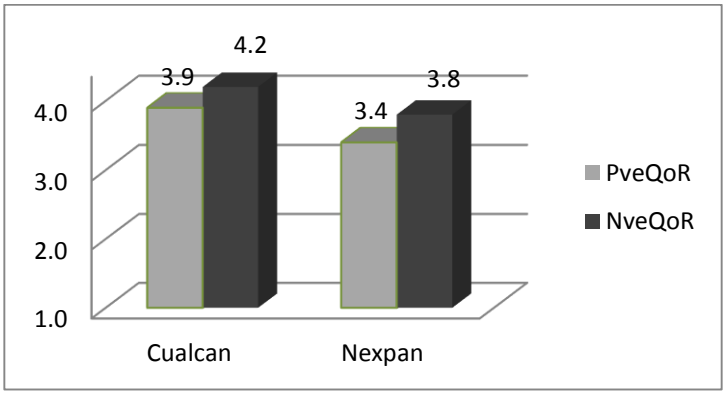
[72] Under this reasoning, the FA conducted for the QoR scale used Promax as rotation method, a method that allows factors to be correlated with each other. The PveQoR and NveQoR factors have a correlation of -0.573 ($p = 0.000$).

This does not imply, however, that positive and negative interactions could not have differential effects and intensities of effects on people's lives and wellbeing. Hence, this separation into two underlying constructs could allow us to explore whether positive and negative aspects in the relationship with officers have a differential role on wellbeing. Namely, if positive aspects could influence certain wellbeing domains whereas negative aspects could affect others. This is done in chapter eight.

Moreover, while the separation of PveQoR and NveQoR might not imply that the quality of a relationship should be understood as having two separate and unconnected dimensions, it could be signalling interesting implications about the measurement of relationships using self-reported indicators. In other words, these findings might reflect methodological concerns about the design of survey questions assessing relationships.

As shown in figure 7.1, on average participants in this sample evaluated the relationship with the medical staff more positively when responding to negatively phrased questions compared to positively phrased questions. Indeed, an overwhelming 74% of recipients in both localities provided higher scores to NveQoR items than PveQoR items, and only 20% did the opposite. This suggests that the factors found in the factor analysis presented earlier could also be reflecting differences in the way participants react towards negatively- or positively-phrased questions, especially in this case that the negative questions tapped on strong themes such as discrimination and humiliation.

**Figure 7.1** Average levels of PveQoR and NveQoR by locality




A few decades ago, Kahneman and Tversky (1979) demonstrated that people's preferences and valuations are highly dependent on how the question is framed. Although this was discussed in the context of willingness to pay, it suggested that if

two questions measuring the same underlying concept are phrased in positive and negative terms separately, people provides a different response to each question. Possibly, in the contexts of this research, the negative wording of questions biased participants to evaluate the relationship less harshly in contrast to positively worded questions. As discussed in chapter six, this issue also indicates that in the future negatively worded questions should be tempered to avoid possible biases.

## 7.4 Conclusion

This chapter provided statistical evidence about the validity and reliability of the two key scales used for this research: Inner Wellbeing (IWB) and Quality of Relationships with Officers (QoR). The factor analytic procedures conducted indicate that in this sample the IWB model takes a structure of eight domains that include Close Relationships (CR), Values and Meaning (VM), Social Connections (SC), Mental Health (MH), Competence and Self-worth (CSW), Political Participation (PP), Economic Confidence (EC), and Social Recognition (SR). In contrast, the QoR scale was separated into two underlying constructs reflecting positive (PveQoR) and negative (NveQoR) interactions.

This chapter also provided discussions about the conceptual and methodological implications of these findings for wellbeing and relationship research as well as for undertaking a mixed method approach. These discussions highlighted, primarily, the difficulty of statistical instruments such as factor analysis to interpret models that are constructed based on qualitative data, as well as heterogeneous models such as IWB which tries to capture diverse aspects of each wellbeing domain rather than simply measuring the same construct with different wording. On the other hand, the factor analysis of the QoR scale pointed towards the difficulty of assessing the quality of relationships through quantitative indicators. These tensions between qualitative and quantitative methodologies make mixing methods more challenging but also more enlightening. As this chapter showed, the qualitative findings helped in the interpretation of the factors obtained for both the IWB and the QoR scales as well as for the decisions made about keeping or dropping any indicators and/or factors from the analysis. Chapter eight applies these resultant scales to answer the main research questions of this dissertation.

# 8. The statistical association between QoR and IWB

## 8.1 Introduction

This chapter is the continuation of the quantitative study introduced in chapter seven. It uses the final set of indicators of QoR and IWB in order to continue with the steps 3 to 5 of the quantitative analysis.

Step three evaluates the relationship between IWB and SWB using correlation and regression analysis. This has the objective of observing the degree of association between the IWB model and the most-used indicators of wellbeing, happiness and life satisfaction. This analysis includes a reflection on the value of the more substantive approach of IWB to understand the wellbeing of these social programme recipients (section 8.2).

Steps four and five have the overall aim of exploring the association between policy-engendered relationships and wellbeing. To do this, however, step four, first conducts a descriptive analysis to identify the differences between participants and localities in their reports of quality of relationships with officers (QoR) and of wellbeing (SWB and IWB) (section 8.3.2). Then, step five scrutinises if the relationship with officers has a significant effect on the wellbeing of recipients and if so, through which channels (domains) it does so (section 8.3.3). This was achieved through the IWB model as it permits the deconstruction of the influence of the QoR indicators on different aspects of people's wellbeing.

This chapter thus investigates the research questions through a series of quantitative tools including analysis of variance, correlation and regression analysis that are explained as the chapter progresses.

## 8.2 The wellbeing of the recipients of *Oportunidades*: A comparison between IWB and SWB

To further explore wellbeing as well as the role of officer-recipient relationships in it, this section assesses the statistical association of the IWB domains with the most used wellbeing approach, SWB.

SWB and IWB have distinct ontological and epistemological stances. SWB understands wellbeing as an experiential phenomenon, focusing on people's cognitive and emotional responses towards their lives as a whole. IWB, in contrast,

looks at wellbeing from a more substantive perspective, defining the constituents of wellbeing based on theory and empirical research and evaluating their quality directly. Even though we know about these conceptual differences, the statistical relationship between SWB and IWB needs to be explored. This section contributes to this gap.

Nonetheless, assessing the quantitative association between these approaches can also give us two different kinds of information that are relevant to this research interested in the wellbeing of social programme recipients.

First, analysing the extent to which the IWB domains explain happiness and life satisfaction can indicate whether the quantitative data corroborates that these (IWB and SWB) are two different constructs of wellbeing. This analysis can also give support to the earlier analysis about the construct validity of IWB as a model of wellbeing in itself, since some association between the two approaches is expected. Yet, having in mind that they have conceptually different stances towards wellbeing, an exact match between them is not likely.

Second, since the global indicators of SWB only tell us a summary indicator of how people are feeling about their lives, the IWB domains can shed light into their meaning in these localities. Namely, by identifying which IWB domains explain and have greater weight on the experience of happiness and life satisfaction for this sample.

Overall, the analysis of the association between IWB as a substantive approach and SWB as an empirical approach to wellbeing is carried out through correlation and regression analysis. The next subsections present the results.

### 8.2.1 Main variables

The variables used for this analysis are the two global indicators of SWB, happiness and life satisfaction presented in chapter four, and the composite indicators of IWB generated from the factor analytic procedures presented in chapter seven. All variables are measured at the individual level and reflect subjective evaluations that people make about their live as a whole (SWB) or about different aspects of their inner wellbeing (IWB domains).

Happiness and life satisfaction remain as ordinal indicators with a 5-point Likert scale that ranges from (1) very unhappy or unsatisfied to (5) very happy or satisfied. In

contrast, the IWB domains extracted from the factor analysis are standardized and continuous variables with mean 0 and standard deviation 1. Yet, to ease interpretability and comparability with the SWB indicators during the descriptive analysis, these were re-scaled into a 1 to 5 metric (see table 8.1).

### 8.2.2 IWB and SWB across the sample

Table 8.1 below shows the descriptive statistics of SWB and IWB. As commonly found in the literature, the average levels of happiness and life satisfaction are significantly associated with one another, displaying a correlation of 0.535 ($p<0.001$). One-way ANOVA tests prove that on average, Nexpan experiences significantly greater happiness ($F(1,310)=6.48$, $p=0.011$) and life satisfaction ($F(1,310)=4.41$, $p=0.036$) than Cualcan. Jointly, however, their average levels are lower than the average levels of happiness and life satisfaction for the nation as a whole, which are 4 and 4.2 respectively according to the BIARE questionnaire collected by INEGI in 2012 (personal calculation).

This is not a surprising result since the participants of this study represent the most deprived and marginalised groups in the nation. The main reasons they are recipients of the *Oportunidades* programme is that they are the group of people in each of their communities that lack basic capabilities such as education, health and income. Indeed, research in Mexico and Latin America has found that while income is a weak predictor of SWB (Rojas 2009a,b; Fuentes and Rojas 2001), other variables such as health (García et al. 2007), education (García et al. 2007, Rojas 2007b, living conditions and access to basic services (Powell and Sanguinetti 2010) are key explanatory variables of the happiness and life satisfaction of Mexicans.

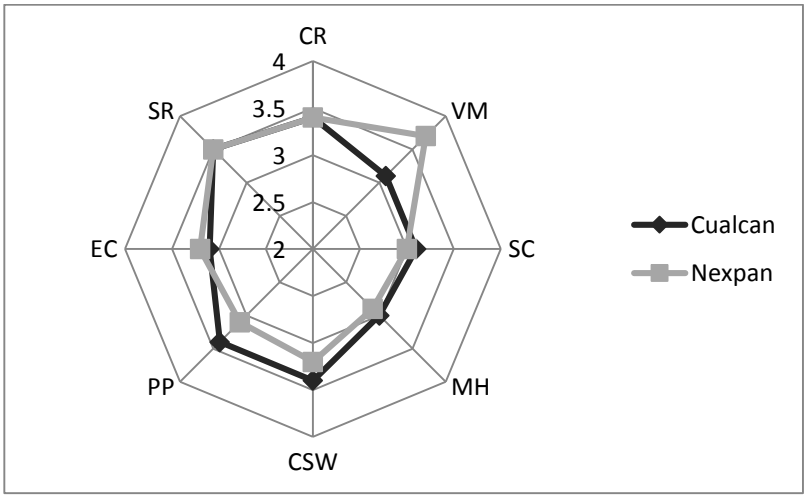
The IWB domains give us a richer picture of the wellbeing outcomes across the sample. The mean levels presented in table 8.1 (and illustrated in figure 8.1) indicate that participants on average reported higher scores for the domains of social recognition (SR), values and meaning (VM), and close relationships (CR) compared to mental health (MH) and social connections (SC) ($F(7,2488)=21.851$, $p<0.001$).

**Table 8.1** Descriptive statistics SWB and IWB

| | Total | | Cualcan | | Nexpan | |
|---|---|---|---|---|---|---|
| | Mean | Std. Dev | Mean | Std. Dev | Mean | Std. Dev |
| SWB | | | | | | |
| Happiness | 3.5 | 0.885 | 3.3 | 0.963 | 3.6 | 0.798 |
| Life Satisfaction | 3.5 | 0.870 | 3.4 | 0.844 | 3.6 | 0.883 |
| IWB | | | | | | |
| Close Relationships | 3.4 | 0.833 | 3.4 | 0.761 | 3.4 | 0.890 |
| Values and Meaning | 3.4 | 0.860 | 3.1 | 0.850 | 3.7 | 0.775 |
| Social Connections | 3.0 | 0.757 | 3.1 | 0.778 | 3.0 | 0.738 |
| Mental Health | 2.9 | 0.583 | 3.0 | 0.620 | 2.9 | 0.547 |
| Competence and Self-worth | 3.3 | 0.793 | 3.4 | 0.788 | 3.2 | 0.796 |
| Political Participation | 3.2 | 0.717 | 3.4 | 0.753 | 3.1 | 0.660 |
| Economic Confidence | 3.1 | 0.691 | 3.1 | 0.672 | 3.2 | 0.708 |
| Social Recognition | 3.5 | 0.668 | 3.5 | 0.639 | 3.5 | 0.694 |
| | n = 312 | | n = 142 | | n = 170 | |

On the other hand, if we look at IWB means by locality, we find that even though Nexpan reports higher SWB than Cualcan, the IWB domains show that this is not the case for all aspects of wellbeing. The IWB in Cualcan and Nexpan is similar in most domains except for values and meaning (VM) and political participation (PP). One-way ANOVA tests indicate that Nexpan experienced significantly higher levels of VM compared to Cualcan ($F(1,310)=39.87$, $p<0.001$), whereas Cualcan shows significantly higher levels of PP compared to Nexpan ($F(1,310)=12.65$, $p<0.001$).

**Figure 8.1** Average IWB by locality



Who experiences greater levels of SWB and IWB in the sample? Indeed, if we analyse the average levels of these wellbeing indicators compared to different groups and personal characteristics in the sample we can find interesting results. To explore these, analysis of variance and correlation analysis were conducted. Analysis of variance is used to test the differences between two or more group means. Whereas correlation analysis tests the strength and direction of the linear relationship between two variables[73].

For the case of SWB, table 8.2 shows that happiness and life satisfaction only correlate with age and years of education[74]. In other words, being younger and having more education is associated with higher reported levels of happiness and life satisfaction, a common finding in the SWB literature. One-way ANOVA tests ($F(2,309)=3.59$, $p=0.029$) and Tukey's HSD post hoc analysis further attest that participants of 33 years old or less were significantly happier than participants of 45 years old or more[75] ($p=0.021$). Similarly, a One-way ANOVA test ($F(2,309)=4.57$, $p=0.011$) and post hoc Tukey's tests confirmed that those who had completed high school were significantly happier compared to those who only completed junior high ($p=0.017$) or primary school ($p=0.022$).

In contrast to SWB, the IWB domains offer a more detailed picture of the association between demographic indicators and the wellbeing experiences of participants. Table 8.2 indicates that the positive association between education and wellbeing in this sample occurred through the domains of close relationships and social recognition. This was supported by a one-way ANOVA test and post hoc Tukey's tests showing that recipients with a high school degree had a significantly better sense of recognition from others compared to recipients who did not have any schooling ($F(2,309)=4.42$, $p<0.05$)[76].

Similarly, the negative relationship between age and inner wellbeing occurred through the domains of competence and self-worth, and economic confidence. This is no

[73] A correlation coefficient of 1 indicates perfect positive fit, whereas a coefficient of -1 indicates perfect negative fit.
[74] Wellbeing was also correlated with age-squared as it has been found in the literature that the relationship between age and wellbeing takes the form of an inverted U-shape. Yet, in this sample the results obtained with age and age-squared were equivalent.
[75] In this sample, the age groups were constructed from a quintile approach (the division of the distribution in equal groups). Three age groups were created: 33 or less, 34 to 44 and 45 or more.
[76] This result could be over-determined, however, since one item of the Social Recognition indicator taps on people's feelings of being ignorant.

surprise since the recipients in both localities often secured their income from labour that was physically intensive, such as being farmworkers. The qualitative interviews corroborate that for elderly participants their age implies that they are more dependent on their children and that their capacity to work decreased importantly. Hence, their confidence of securing enough income to meet their daily needs was even more compromised at this stage of life. On the other hand, although mental health was not correlated to any demographic indicator, a one-way ANOVA ($F(2,309)=8.54$, $p<0.001$) and Tukey's HSD tests suggested that the youngest (33 years or less) and oldest (45 or more) recipients in the sample experienced significantly higher levels of mental health compared to recipients between the ages of 34 and 44 ($p<0.001$).

**Table 8.2** Correlations IWB and SWB against demographics

| | Age | Years of education | Years in Oportunidades | Cash transfer (MXP) | Housing |
|---|---|---|---|---|---|
| Happiness | -.147** | .118* | -.107 | -.010 | .078 |
| Life Satisfaction | -.107† | .136* | -.074 | -.007 | .042 |
| Close Relationships | -.033 | .152** | -.003 | .009 | .195** |
| Values and Meaning | .023 | .040 | -.106 | .048 | .138* |
| Social Connections | .090 | -.085 | .062 | .030 | .081 |
| Mental Health | -.033 | .012 | -.092 | -.015 | -.008 |
| Competence and Self-worth | -.102† | .022 | .014 | -.027 | .082 |
| Political Participation | .003 | .068 | .154** | .046 | -.002 |
| Economic Confidence | -.101† | .071 | -.058 | -.013 | .137* |
| Social Recognition | -.081 | .223** | -.020 | .029 | .103 |

Pearson correlations (2-tailed), ** p < 0.01, * p < 0.05, † p-value < 0.1

The length participants had been part of the *Oportunidades* programme was not associated with their happiness or life satisfaction. The only aspect of inner wellbeing that was significantly correlated to this was political participation[77]. This coefficient suggested that being recipient for longer is related to higher feelings of being able to express opinions and protest within their localities.

[77] There is a possible two-way causation in this result. That is, in addition to the previous direction of causality, it is also possible that people with greater sense of political participation used it to enter and remain in *Oportunidades*.

If we were to evaluate the relationship between the programme and the recipients' wellbeing outcomes, the number of years of adherence to *Oportunidades* and the amount of cash transfer perceived were not associated with any wellbeing domains (except for that explained above), including economic confidence. The fact that no relationship was found between the size of the cash transfer and perceived wellbeing was not expected since during the qualitative interviews, recipients constantly described the cash transfer as a vital security net. In many cases, the cash transfer was the only secure income they obtained and important expenditure decisions were taken around the dates that the transfer was made. These decisions affected not only their immediate needs such as food expenditure, but also investments in children's clothing, education and basic needs, improvements in housing conditions, and even debt relief. These results could be interpreted as a sign that this dependence on the cash transfer might not make people feel better about their economic confidence overall.

The quality of people's housing was used as a proxy of economic position and wealth. The housing indicator was measured at the household level and generated from questions about the quality of dwelling and infrastructure (i.e. sources of water, sanitation facilities, type of flooring, and overall house construction materials)[78]. The correlation analysis with all wellbeing measures indicated that even though housing was not associated with happiness or life satisfaction, the quality of people's close relationships, their sense of meaning in life and their economic confidence was positively and significantly correlated to the quality of their housing conditions.

So far the descriptive analysis of wellbeing depicted which recipients are better off and what aspects of wellbeing are associated with different demographic indicators and to the *Oportunidades* programme. This analysis also showed that it is through the IWB domains that the wellbeing experiences of participants can be more profoundly evaluated. Whereas the SWB indicators suggested that the happiest and most satisfied people in the sample are the younger and more educated recipients, the IWB model allowed a deeper analysis into the pathways through which these demographic indicators influence wellbeing. Being able to disaggregate in different

[78] These variables were assigned an incremental weight based on the conceptual quality of the indicator (e.g. the water indicator was coded as (1) no piped water, (2) piped water from neighbour/other, (3) piped water into residence). Despite the limitations of constructing a proxy of relative economic position based on these indicators, recent studies have validated and recommended the use of this approach in contexts such as Cualcan and Nexpan in which measuring income and consumption expenditure is more challenging due to the variability and diversity of the income sources, to give an example (e.g. Moser and Felton 2007).

domains, therefore, uncovers interesting relationships that could be explored more deeply in the future.

### 8.2.3 The association between IWB and SWB

The previous descriptive analysis revealed that IWB and SWB do not always concur about the connection between people's personal and economic characteristics and their wellbeing outcomes. While this could be interpreted as giving initial indications of the different characteristics of these approaches, it does not clarify what is the specific relationship between SWB and IWB. To explore the association between these two conceptual understandings of wellbeing correlation and regression analyses were conducted. These are explained in the subsequent sections, commencing with correlation analysis.

#### 8.2.3.1 Correlation analysis

The analysis of the relationship between IWB and SWB was explored initially using the sample as a whole. As it was found in the previous section, the samples in Nexpan and Cualcan do not show large or consistent wellbeing differences. For this reason, hereafter the analysis was conducted collapsing the data across locality (it is nonetheless advisable to test for differences across contexts in any new sample).

Table 8.3 presents the pattern of Pearson's correlations between the two indicators of SWB, happiness and life satisfaction, and all domains of IWB constructed for this sample. As was expected, most domains of IWB depict a significant and positive relationship with happiness and life satisfaction (except for the domain of political participation which is not significant). While correlation does not imply causation, it confirms that the higher the IWB of participants, the higher their happiness and life satisfaction (and vice versa).

This table also reveals that although the sizes of the relationships are moderate, not all correlations are equally important[79]. The highest correlation of both happiness and life satisfaction with IWB is found in the domain of close relationships (CR) with a

[79] The results of this analysis concur with those by Fernandez et al. (2014) who found significant but slightly stronger relationships between the IWB indicators and happiness.

coefficient of approximately 0.4. As shown in chapter two, this is consistent with several studies conducted in Mexico (e.g. Rojas 2004b, 2007) and internationally that attest that family relationships are the greatest source of happiness and life satisfaction. In the case of happiness, the correlation with close relationships (CR) is followed by the domain of mental health (MH), whereas life satisfaction is followed by values and meaning (VM).

**Table 8.3** Pearson correlation IWB and SWB

| IWB | Happiness | Life Satisfaction |
|---|---|---|
| Close Relationships | .36** | .39** |
| Values and Meaning | .25** | .35** |
| Social Connections | .22** | .27** |
| Mental Health | .27** | .19** |
| Competence and Self-worth | .11† | .20** |
| Political Participation | .01 | .08 |
| Economic Confidence | .22** | .25** |
| Social Recognition | .14* | 0.10† |

Observations: 312

** p-value < 0.001, * p-value < 0.05, † p-value < 0.1

The domain of social connections lies in third place for life satisfaction and fourth for happiness, both closely followed by the domain of economic confidence. Mental health (MH) is more strongly associated with happiness than with life satisfaction, whereas with competence and self-worth (CSW) the opposite occurs. In turn, in both SWB indicators, correlations with the domain of Social Recognition (SR) are positive but low and correlations with Political Participation (PP) are non-significant.

These findings are initial indications of two things. First, whereas IWB and SWB are measuring wellbeing, they are not capturing the same thing. As expected, the direction of the association between SWB and IWB domains is consistently positive. Nonetheless, the strength of their association varies with each domain of IWB. Second, this analysis of linear relationship also confirms the centrality of relationships for the SWB of this sample. It shows that CR is the domain that is most strongly associated with happiness and life satisfaction, with the domain of SC positioned a few places behind.

It is nonetheless important to go beyond correlation analysis to find the relative association of each IWB domain with the happiness and life satisfaction of the

*Oportunidades* recipients in this sample. Hence, the next sub-section presents the regression analysis used to explore this more deeply. Before moving ahead, however, it is important to note that the regression analysis conducted here is not based on the assumption that IWB domains are either determinants or components of happiness. For this dissertation IWB and SWB are simply different approaches to wellbeing, they measure distinct constructs or understandings of wellbeing. The aim of using quantitative analysis to explore their association is simply to understand which domains of IWB are linked to how the people in the sample responded to the SWB questions.

#### 8.2.3.2 Regression analysis

Regression analysis is a commonly used method within wellbeing research to evaluate the nature of relationships between indicators. This statistical tool explores functional relationships between variables (Gujarati and Porter 2009). In the happiness and domain satisfaction literatures, regressions are often used to understand which variables explain SWB and what is their relative explanatory power (how important they are) taking into account other variables (e.g. Rojas 2006). Regression analysis is used here to study how much of the change in participants' happiness and life satisfaction is associated with the IWB domains.

The type of regression analysis depends on the nature of the data and the variables. For this cross-sectional study using ordinal dependent variables (the SWB items are ordinal and measured in a 5-point Likert scale), wellbeing researchers usually opt either for Ordinal Least Square (OLS) models or Ordered Probit models. There was some debate about which is the best model to use. However, in recent years many SWB scholars have opted for OLS models for their easier interpretability but also because it has been found that they deliver equivalent results[80]. Similarly, Garson (2012) supports the use of ordinal dependent variables in OLS estimation as long as

[80] The type of regression analysis is chosen depending on the nature of the data and on the assumption of ordinality or cardinality of the dependent variable. Using life satisfaction indicators, Frey and Stutzer (2002) find that the assumptions of cardinality and ordinality of OLS and Ordered Probit models generate quantitatively similar results (see also Frey et al. 2010). Given these findings, even when the dependent variable is ordinal, Headey and Wooden (2004) propose using OLS models for their easier interpretability. Ferrer-i-Carbonell and Frijters (2004) offer a thorough analysis of this.

the variable has at least 5 response categories. Following this literature, OLS models were conducted to explore the relationship between IWB and SWB.

The model specification is thus a linear regression model based on the following general model:

$$\mathrm{SWB_i} = IWB_i(IWB_1 \ldots IWB_n, \gamma_\mathrm{i}),\ \mathrm{n=8}$$

Where $\mathrm{SWB_i}$ represents the happiness or life satisfaction of each i participant in the sample and $\mathrm{IWB_i}$ stands for her inner wellbeing outcomes in each of the 8 domains. A normally-distributed error term is represented by $\gamma_i$.

More specifically two regressions were conducted:

$$\mathrm{H_i} = \delta_0 + \delta_1\mathrm{CR_i} + \delta_2\mathrm{VM_i} + \delta_3\mathrm{SC_i} + \delta_4\mathrm{MH_i} + \delta_5\mathrm{CSW_i} + \delta_6\mathrm{EC_i} + \delta_7\mathrm{PP_i} + \delta_8 SR_i + \mu_\mathrm{i}$$

$$\mathrm{LS_i} = \beta_0 + \beta_1\mathrm{CR_i} + \beta_2\mathrm{VM_i} + \beta_3\mathrm{SC_i} + \beta_4\mathrm{MH_i} + \beta_5\mathrm{CSW_i} + \beta_6\mathrm{EC_i} + \beta_7\mathrm{PP_i} + \beta_8 SR_i + e_\mathrm{i}$$

Where:

$H_i$: Happiness of person *i*, in a 1 to 5 scale.
$LS_i$: Life satisfaction of person *i*, in a 1 to 5 scale.
$CR_i$: the quality of *Close Relationships* of person *i*, in a 1 to 5 scale.
$VM_i$: the *Values and Meaning* of person *i*, in a 1 to 5 scale.
$SC_i$: the quality of *Social Connections* of person *i*, in a 1 to 5 scale.
$MH_i$: the *Mental Health* of person *i*, in a 1 to 5 scale.
$CSW_i$: the *Competence* of person *i*, in a 1 to 5 scale.
$EC_i$: the *Economic Confidence* of person *i*, in a 1 to 5 scale.
$PP_i$: the *Political Participation* of person *i*, in a 1 to 5 scale.
$SR_i$: the *Social Recognition* of person *i*, in a 1 to 5 scale.
$\mu_i$ and $e_i$: error term of person i for each regression.
$\delta_j$ and $\beta_j$: the parameters to be estimated in each regression, j = 0 to 7.

The regressions and the assumptions they need to satisfy were explored using Stata version 13.0.

*Assumptions*

The results suggest that the residuals of these regressions are homoscedastic. Homoscedasticity signifies that the residuals are equally distributed over the predicted values for all dependent variables in the regression. This was evaluated using the Breusch-Pagan/Cook-Weisberg test confirming that the models present constant variance[81].

**Table 8.4** Linear Regression analysis of $SWB_i$ over $IWB_i$

| | Happiness | Life Satisfaction |
|---|---|---|
| Constant | 1.045* | 0.704† |
| Close Relationships | 0.248** | 0.206** |
| Values and Meaning | 0.121* | 0.224** |
| Social Connections | 0.083 | 0.130* |
| Mental Health | 0.232* | 0.087 |
| Competence and Self-worth | 0.001 | 0.069 |
| Political Participation | -0.077 | -0.009 |
| Economic Confidence | 0.158* | 0.207** |
| Social Recognition | -0.006 | -0.058 |
| R-squared | 0.197 | 0.244 |

** p-value < 0.001, * p-value < 0.05, † p-value < 0.1
Observations: 312

For the regression results to be valid, the independent variables in the models need to not be highly correlated with each other to avoid problems understanding which variable contributes to the variance explained by the model. For this the Variance Inflation Factor test was conducted. The mean coefficient of 1.24 for both models (since the same independent variables are introduced in both regressions) giving consistent evidence that these models did not suffer from a collinearity problem. These post-estimation results and the satisfaction of these assumptions justify the interpretation of the results of these regression models. Table 8.4 presents the results of the two models described above following OLS estimation.

*Findings*

The goodness of fit statistic or coefficient of determination R-squared describes the explanatory power of the independent variables over the dependent variable. In other words, R-squared indicates how much the IWB model overall explains the variation

[81] The results for the Happiness regression are: Chi-squared(1)=1.17, prob>chi2=0.28. The results for the Life satisfaction regression are: Chi-squared(1)=2.29, prob>chi2=0.13.

in happiness and life satisfaction. The coefficient of determination of each regression is presented at the bottom of table 8.4, showing that IWB explains 20% of the variation of happiness and 25% of the variation of life satisfaction.

Similarly, table 8.4 presents the coefficients and significance levels (denoted by the stars (*)) of each domain of IWB as predictor of happiness and life satisfaction. It is observed that whereas the IWB model predicts both happiness and life satisfaction, not all domains are equally strong or significant for both indicators of SWB. In the case of happiness, the domain of close relationships (CR) has the highest coefficient, closely followed by mental health (MH). Happiness was also explained by the domains of economic confidence (EC) and values and meaning (VM), with the latter being the weakest predictor. On the other hand, life satisfaction is also positively and significantly related to the domains of values and meaning (VM), economic confidence (EC), close relationships (CR), and social connections (SC). Finally, the domains of competence and self-worth (CSW), political participation (PP) and social recognition (SR) are not significant either for happiness or life satisfaction.

Whereas some connection was expected between IWB and SWB, the conceptual differences between the two were also reflected in the moderate explanatory power of the IWB model in the regressions (the values of the goodness of fit indicator R-squared). Clearly, IWB measures and understands wellbeing in a different way than SWB. For instance, it includes the domains of CSW, SR and PP that are not accounted for in the variation of happiness or life satisfaction – at least in this sample. However, the significance of these domains on wellbeing is not only justified by the results of the factor analysis of the IWB model but is supported by the qualitative findings of this research. Indeed, in addition to being central aspects of the participant's wellbeing narratives, their sense of competence and self-worth, political participation, and social recognition were influenced by the quality of their relationships with the medical staff in the clinic, the focus of this dissertation. One interpretation of these results could be that, while the IWB model is indeed associated with SWB, it includes aspects of wellbeing that are not captured by either happiness or life satisfaction. Therefore, the multidimensional and psychosocial model of IWB could be offering a distinctive and probably a more comprehensive picture of the experience of wellbeing.

The analysis that was just presented provides interesting insights about the relationship between a hedonic approach to wellbeing (SWB) and a psychosocial

approach (IWB). Research in other samples and contexts could be useful to continue exploring the statistical relationship between them. In terms of the effect of each domain on subjective wellbeing, this analysis confirms that close relationships, economic confidence, and values and meaning are essential for the subjective wellbeing (happiness and life satisfaction) of recipients. Yet, to explore the role that the quality of the relationship with the health staff has on wellbeing, further analysis was conducted. This is presented in the next section.

## 8.3 Wellbeing and the quality of the relationship with front-line officers

The previous sections showed the value of taking a substantive (psychosocial) and multidimensional model of wellbeing such as IWB. IWB allows for a deconstruction of wellbeing into different domains or aspects that are central for people's lives. Yet, although its association with SWB is not absolute, it confirms that IWB can explain people's reports about happiness and life satisfaction. IWB represents a comprehensive measure of wellbeing and this is supported both by theory and by empirical analysis in Mexico as well as India and Zambia.

The multidimensionality of IWB allows us to explore what are the channels through which officer-recipient relationships are associated with wellbeing. This is investigated by analysing the association between the quality of the relationship with *Oportunidades* health officers (QoR) and the inner wellbeing outcomes of recipients.

This section is structured as follows. First, it describes the main variables and methods used to respond to this research question. Then, variation of QoR across the sample is explored, particularly focusing on reports of the affiliation with the *Oportunidades* programme and the recipients' perception of the local clinic. Finally, correlation and regression analyses are employed to understand the impact that QoR has on the different IWB domains. The regression analysis is controlled by key demographic variables that are known drivers of wellbeing (e.g. age, education, employment, housing, etc.).

### 8.3.1 Main variables and methods:

The variables that used in this analysis are the following:

Firstly, the eight composite indicators of IWB generated from the factor analytic procedures presented in chapter seven, section 7.3.1. Secondly, the two composite indicators of QoR (PveQoR and NveQoR) also constructed from the factor analysis in section 7.3.2. For the initial descriptive analysis all items were standardized and re-scaled to a 5-point Likert scale to simplify interpretation.

Finally, the group of demographic variables included are: locality, age, years of education, living with partner, being employed, amount of cash transfer received, household size, and quality of housing as proxy of wealth. Most of these are well known drivers of wellbeing (e.g. Dugain and Olaberriá 2015) and therefore are used not only to describe the variability of QoR and IWB across the sample, but also as control variables in the regression analysis.

### 8.3.2 QoR and IWB across the sample

Table 8.5 below presents the descriptive statistics of the two indicators of quality of relationships with the health officers (PveQoR and NveQoR). The mean scores of both indicators are relatively high, although on average Nexpan reports a relatively worse relationships compared to Cualcan in both indicators. A one-way ANOVA test was conducted to test the statistical difference between these mean scores, confirming a significantly worse relationship in Nexpan in both indicators, PveQoR ($F(1,310)=27.27$, $p<0.001$) and NveQoR ($F(1,310)=11.76$, $p=0.001$). To be clear, on average, participants in Nexpan reported significantly lower levels of positive interactions (3.3) and higher levels of negative interactions with the health staff (2.2) than in Cualcan (with average scores of 3.8 and 1.9 respectively).

Consistently with the qualitative findings, these mean scores indicate that Nexpan is the locality that experienced a worse relationship with health officers. Yet, overall, participants evaluated the relationship relatively positively since these scores for PveQoR lie above the average value of 3 in the scale and for NveQoR lie below[82].

[82] The higher the value of PveQoR the more positive the relationship is. In contrast, the higher the value of NveQoR the more negative the relationship is.

The fact the quantitative analysis shows relatively positive results, contrasts with the negative reports found in the qualitative analysis that were reported in chapter six. This incongruence between how relationships are evaluated in the qualitative and quantitative studies could have two interpretations.

**Table 8.5** Descriptive statistics PveQoR and NveQoR

| | Total Sample | | Cualcan | | Nexpan | |
|---|---|---|---|---|---|---|
| | Mean | Std. Dev | Mean | Std. Dev | Mean | Std. Dev |
| PveQoR | 3.6 | 0.864 | 3.8 | 0.721 | 3.3 | 0.911 |
| NveQoR | 2.1 | 0.852 | 1.9 | 0.711 | 2.2 | 0.930 |
| | n = 312 | | n = 142 | | n = 170 | |

One possible explanation for this inconsistency is that participants in these contexts could have experienced a positive bias or social desirability bias when faced with the precise and tangible essence of survey questions. A similar experience has been reported in other countries when measuring quality of relationships. The Wellbeing Pathways research group in the context of Zambia (White and Jha 2014) and India (Jha and White 2015) found that participants tended to evaluate their close relationships more positively in the survey questions (used to measure the domain of Close Relationships of the IWB model) than they did in the qualitative interviews. In the face of these results, White and Jha (2014) emphasised the need to further examine the implications of wording in the measurement of quality of relationships.

Whereas close relations are a different kind of relationship, the literature on client-provider interactions in the context of health (Simmons and Elias 1994 and Merkouris et al. 2004) has also problematized the measurement of clients'/patients' subjective evaluations of their interactions with physicians. Simmons and Elias (1994) highlight a number of findings in Northern and Southern countries where quantitative and qualitative results are in contradiction. Indeed, quantitative indicators typically reveal high levels of client satisfaction while qualitative studies show extensive evidence of dissatisfaction. A possible reason for this contradiction according to Simmons and Elias (1994) are issues of 'courtesy' biases in people's responses to quantitative indicators since "people are often unwilling to reveal their views to someone with whom they have not established extensive rapport and trust" (p.9). In contrast, Merkouris and colleagues (2004, p.356) suggest that other possible explanations are patient's "social conformity and/or dependence" on health staff as well as a difficulty

of discerning between the quality of care received and other aspects of health provision.

In this study, however, participants might have felt that their answers to such questions could have real repercussions in the future, either for them or for the health staff. Indeed, for this sample this positive bias might have been increased by a fear of retaliation that recipients expressed during the qualitative interviews. The fear voiced was that if officers find out how recipients were evaluating them, they could act against recipients by, for example, taking them out of the programme. This fear could have been more acute in the surveys than in the interviews since the surveys were applied in the clinics themselves (though without the health staff present)[83].

More importantly, these results suggest a limitation of surveys to capture certain aspects of relationships that were observed in qualitative data. For example, Simmons and Elias (1994) argue that "surveys cannot assess adequately such factors as the technical quality of care provided, nor can they reflect easily the complex feelings and perspectives of clients or the underlying dynamics of power and status" (p.9).

While the former evidence points towards the difficulty of measuring relationships quantitatively, another interpretation of the contradictory results of qualitative and quantitative data is that during qualitative commentary people tend to privilege negative experiences while taking for granted the positive experiences with health officers. In other words, in a conversation, negative interactions could be more immediately available in their recollections of their interactions with officers or can more easily turn into an interesting discussion among participants (e.g. in focus groups), than positive interactions.

Since this dissertation takes the position that neither form of elicitation provides the 'real' or 'single truth' about the nature of the relationship between officers and recipients, both need to be contrasted and analysed to understand better what is happening in these interactions. Even though more research is necessary, these divergent results give additional support to the need of taking a mixed-methods perspective in the study of such complex issues like the quality of relationships.

[83] As noted in the methodology chapter, the recipients were consistently reassured that their responses to the survey questions were anonymous and their identity would be safeguarded.

### 8.3.2.1 QoR and the affiliation to *Oportunidades*

The variation in the quality of the relationship with the officer was explored given the different characteristics of the recipients' affiliation to *Oportunidades*. Table 8.6 displays the mean levels of PveQoR and NveQoR in total and by locality when recipients have different roles in the programme, and who report having the clinic as their first choice to seek medical attention.

**Table 8.6** Descriptive analysis of QoR by affiliation to *Oportunidades*

| | | Total | | Cualcan | | Nexpan | |
|---|---|---|---|---|---|---|---|
| | | Pve QoR | Nve QoR | Pve QoR | Nve QoR | Pve QoR | Nve QoR |
| Role in Oportunidades | Recipient | 3.6 | 2.1 | 3.9 | 1.9 | 3.3 | 2.3 |
| | Other roles | 3.4 | 2.1 | 3.6 | 2.0 | 3.3 | 2.2 |
| Choice for medical attention | Local Clinic | 3.7 | 1.9 | 3.9 | 1.8 | 3.6 | 2.0 |
| | Other | 3.2 | 2.4 | 3.7 | 2.2 | 3.1 | 2.5 |

In terms of the differences between those recipients who have direct contact with the health staff due to their role as *vocales* or as committee health workers[84], the one-way ANOVA tests show that those who declared to have had a role in the clinic/programme experienced significantly lower levels of positive interactions with staff compared to those who only have acted as recipients during their time in the programme ($F(1,310)=6.332$, $p=0.012$). This significant difference appears to be driven by the locality of Cualcan in which *vocales* and health committee members report experiencing significantly lower positive interactions (3.6) compared to those who are only recipients (3.9) ($F(1,140)=4.336$, $p=0.039$). In Nexpan, even though on average they experienced lower levels of PveQoR, no significant differences were found between these two groups of recipients. Overall, these results could indicate that those recipients who had more frequent contact with the officers due to their role in the relationship (practically acting as unpaid employees rather than clients) experienced a less positive interaction with the health staff.

A relatively bad interaction with the health officers that implement *Oportunidades* could also have implications in the attitudes that recipients take towards the clinic.

[84] In this data set no differentiation was made between *vocales* and health committee members since some participants reported acting in either role in the recent past (a month before the fieldwork was conducted the members of the health committees in both localities changed). This indicated that it was not going to be possible to discern between present and previous experience. Thus, this variable captures those recipients that had acted or were currently acting in either role.

This was explored by asking recipients about the first place they would resort to when requiring medical attention (particularly non-compulsory medical attention). Analysis of variance shows that people who did not choose the local clinic as their first option, reported significantly lower positive interactions ($F(1,310)=27.163$, $p<0.001$) and higher negative interactions ($F(1,310)=23.534$, $p<0.001$) with the health staff. If we evaluate differences by localities, recipients in Cualcan only reported significantly worse negative interactions ($F(1,140)=6.065$, $p=0.015$), whereas in Nexpan they declared both significantly lower positive interactions ($F(1,168)=14.883$, $p<0.001$) and higher negative interactions ($F(1,168)=9.933$, $p=0.002$). Although further research is required, these results could suggest that a relatively worse relationship is associated with recipients choosing other options (including private doctors or traditional healers) when seeking medical attention for their ailments.

These findings denote the implications of the relationship with officers for the health and wellbeing of recipients. Implications that could threaten the final effect of *Oportunidades* as a result of the relationships created during the implementation process. However, in order to make more conclusive claims, this dissertation conducted correlation and regression analyses which show a clearer picture of the pathways through which this policy-engendered relationship could be impacting what should be the aim of any social policy, the wellbeing of its recipients. These are presented in the next section.

### 8.3.3 The association between QoR and IWB

#### 8.3.3.1 Correlation analysis

The Pearson's correlations between PveQoR and NveQoR with all IWB domains show interesting results (table 8.7). First, all significant correlations are positive and low. A low score was expected as the quality of the relationship with the health officers was not likely to be a large determinant of people's wellbeing since there are many other aspects of their lives (including other relationships) that could be more relevant to each domain.

Despite the low coefficients, the overall assessment shows that having a positive relationship with officers (measured by positive indicators such as respect, kindness and the like through PveQoR), is significantly associated with wellbeing outcomes in the domains of close relationships (CR), social connections (SC), political

participation (PP), economic confidence (EC) and social recognition (SR). On the other hand, having a more negative relationship (measured by indicators such as discrimination and humiliation through NveQoR) is significantly correlated with lower wellbeing outcomes in the domain of social recognition (SR).

**Table 8.7** Correlation QoR Scales and IWB domains

| | PveQoR | NveQoR |
|---|---|---|
| Close Relationships | .113* | -.025 |
| Values and Meaning | .060 | .012 |
| Social Connections | .115* | -.009 |
| Mental Health | .090 | -.071 |
| Competence and Self-worth | .035 | .071 |
| Political Participation | .142* | -.037 |
| Economic Confidence | .103† | -.045 |
| Social Recognition | .121* | -.131* |

** p < 0.001, * p < 0.05, † p < 0.1
Observations: 312

If we take a closer look, the link between CR and SC with PveQoR might be capturing two things. First, the three are measures of quality of relationships. Therefore, the correlation might be capturing the personal characteristics of the participant with regards to relationships in general. These personal characteristics could include the participant's tendency to have positive or negative relationships all together, either with their family, their locality, or the health officers.

Secondly, the significant correlation with SC could indicate that the relationship with the health officers is one part of the social connections domain of recipients. Since the relationship with the health officers has become a constant and important interaction in the life of recipients due to the part officers play in the regulation of the conditions of *Oportunidades*, it could have become one part of a better quality of social connections within the inner wellbeing of recipients.

On the other hand, the political participation domain is particularly measuring the extent to which people feel that they can use their agency in their town and when interacting with an authority. Therefore, the association between PveQoR and PP can indicate that if the relationship with the health officers is more positive, this is associated with a higher sense of being able to express a complaint and an opinion in social scenarios but also in interaction with authorities such as the health staff itself.

This was illustrated in a number of excerpts from conversations with programme recipients in the qualitative study.

The positive and significant relationship between EC and PveQoR is also an interesting finding. To interpret this finding it is relevant to remind the reader that the health officers are in charge of regulating the conditions of the programme and therefore are key for the recipients' stay in the programme. In this context, a positive and significant correlation between the PveQoR and the recipients' economic confidence is no surprise. The more positive relationship with the health officers might imply that recipients are less afraid of losing the cash transfer. This was declared by many participants in the qualitative interviews as well as the centrality of the cash transfer as a security net during their (constant) times of economic hardship (see chapter six).

Finally the domain of SR is associated both with PveQoR and NveQoR, showing that more expressions of respect and fewer expressions of humiliation and discrimination in their interactions with health officers are linked to recipients having a greater sense of worth or recognition from others. These results should not be a surprise given the findings from the qualitative analysis presented in chapter six.

So far the descriptive analysis shows that recipients in Cualcan have a better QoR with health officers measured by both PveQoR and NveQoR. Furthermore, it showed that QoR - positively and negatively measured - is linked to IWB principally through the domains of CR, SC, PP, EC and SR. Despite some of the limitations in the measurement of QoR, these results largely confirm the qualitative findings so far. However to explore whether the association between QoR and IWB outcomes remains after controlling for the personal characteristics of participants and by locality, regression analyses are undertaken. The procedures and the results are presented in the next subsection.

#### 8.3.3.2 Regression analysis

The regression analyses were conducted in two stages. First, to isolate the effect of QoR over IWB, a set of eight regressions were conducted with each domain of IWB as dependent variables and only the two indicators of QoR as independent variables (model 1). Second, another set of eight regressions were conducted to explore

whether PveQoR and NveQoR remained significant when demographic characteristics are accounted for (model 2).

The main variables used are: As dependent variables, each of the eight standardized composite factors of the IWB domains; namely CR, VM, SC, MH, CSW, PP, EC, and SR. The independent variables comprise the two standardized composite factors of quality of relationships with the health officers PveQoR and NveQoR and data on demographic characteristics presented in section 8.3.1. Table 8.8 presents the descriptive statistics of the two indicators of QoR and the demographic variables.

**Table 8.8** Descriptive statistics independent variables

| | Total Sample | |
|---|---|---|
| | Mean | Std. Dev |
| QoR | | |
| PveQoR | 0.0 | 1.000 |
| NveQoR | 0.0 | 1.000 |
| Demographics | | |
| Role in programme | 0.35 | 0.479 |
| Age | 40 | 12.580 |
| Years of education | 8.2 | 4.0 |
| Living with partner | 0.79 | 0.411 |
| Working | 0.74 | 0.441 |
| Cash Transfer | 1133.04 | 615.660 |
| Household Size | 5.57 | 2.551 |
| Housing | 0.61 | 0.216 |

Observations: 312

*Model 1: Simple regressions of QoR and IWB domains*

The subsequent equation expresses the general form of Model 1.

$$\mathrm{IWB_{ij}} = \beta_o + \beta_1 \mathrm{PveQoR_i} + \beta_2 \mathrm{NveQoR_i} + \mu_i$$

Where:

$IWB_{ij}$: the inner wellbeing of person *i* measured by each of the *j* domains of the IWB model (CR, VM, SC, MH, CSW, EC, PP and SR, with j = 1 to 8). All dependent variables are in a 1 to 5 scale.

$PveQoR_i$: the positive interactions with the health officers reported by person *i*, in a standardized scale[85].

$NveQoR_i$: the negative interactions with the health officers reported by person *i*, in a standardized scale[86].

$\mu_i$: the error term of person i for each regression.

$\beta$: the parameters to be estimated in each regression.

### *Assumptions*

Assumptions were tested, finding that the residuals of all regressions are homoscedastic (have constant variance) using the Breusch-Pagan/Cook-Weisberg test, except for regressions with MH and PP as dependent variables[87]. On the other hand, no collinearity was present between the independent variables in the models according to the Variance Inflation Factor test that offered a mean coefficient of 1.49 for all models since the same independent variables are introduced. The satisfaction of these assumptions justifies the interpretation of the results, although the regressions of MH and PP should be interpreted with caution due to possible heteroscedasticity present. The output of the linear regression analysis following OLS estimation and conducted in Stata 13 is presented in table 8.9.

**Table 8.9** Regressions $IWB_i$ over PveQoR and NveQoR

| | CR | VM | SC | MH | CSW | PP | EC | SR |
|---|---|---|---|---|---|---|---|---|
| PveQoR | 0.123* | 0.086 | .124* | 0.043 | 0.089 | 0.129** | 0.079† | 0.046 |
| NveQoR | 0.050 | 0.060 | 0.064 | -0.017 | 0.107 | 0.048 | 0.015 | -0.062 |
| Constant | 3.38** | 3.43** | 3.03** | 2.92** | 3.30** | 3.225** | 3.14** | 3.47** |
| R-square | 0.015 | 0.007 | 0.018 | 0.009 | 0.014 | 0.023 | 0.011 | 0.02 |

Observations: 312

** p-value < 0.001, * p-value < 0.05, † p-value < 0.1

[85] The QoR indicators used were the standardized scores obtained from the factor analysis to avoid any issues of multicollinearity in the regression analysis due to the interaction effects introduced.

[86] The NveQoR indicator remained in its original reverse code to ease interpretability (i.e. the higher the score, the more negative the interaction with officers).

[87] MH: Chi-squared(1)=9.96, prob>chi2=0.0016. PP: Chi-squared(1)=5.78, prob>chi2=0.016.

*Findings*

The results denote that the interactions with the health officers show a significant and positive effect on the IWB of recipients only when measured by positively phrased questions (PveQoR). Moreover, PveQoR explains the wellbeing outcomes for the domains of close relationships (CR), social connections (SC), economic confidence (EC), and political participation (PP). In sum, these findings imply that as participants experience more positive interactions with the health officers, their wellbeing improves in the domains mentioned. In contrast, the quality of the interactions with officers do not have a significant effect in the domains of values and meaning, mental health, and competence and self-worth. If we compare these results with the correlation analysis previously conducted, we can see that in the regressions the explanatory power of QoR on SR is dropped.

*Model 2: Regressions of QoR and IWB domains controlling for personal characteristics*

Model 2 presents the same group of eight regressions but now controlling for demographic variables and variables that are known to be key drivers of wellbeing (see e.g. Dugain and Olaberriá 2015). Hereafter, the regressions take into account most of the relevant characteristics of the individual in order to elicit whether those relationships between QoR and IWB still hold.

This model also includes an interaction effect with the variable *Drole*. This dummy variable separates the sample between those who act only as recipients and those who have acted as *vocales* or members of the health committee within *Oportunidades* and the clinic. This variable and its interaction with both indicators of QoR ($PveQoR_iDrole_i$; $NveQoR_iDrole_i$) were introduced to the regressions given the results presented in section 8.3.2.1 that find *vocales* and committee members reporting significantly worse interactions with officers.

These variables test whether having closer and more frequent interactions with officers is linked with a stronger effect on wellbeing. If the coefficient is positive, the effect of QoR on wellbeing is stronger for those recipients who have a role in *Oportunidades* than for those who are only recipients. On the other hand, if the coefficient is negative, the effect of QoR on wellbeing is lower for *vocales* and health committee members than for the average recipient.

The generic model can be expressed as follows.

$$\mathrm{IWB_i} = \beta_o + \beta_1 \mathrm{PveQoR_i} + \beta_2 \mathrm{NveQoR_i} + \beta_3 \mathrm{PveQoR_i Drole_i} + \beta_4 \mathrm{NveQoR_i Drole_i} + \beta_5 \mathrm{Drole_i} + \beta_6 z_i + \mu_i$$

Where $z_i$ represents a vector of the control variables in the regression:

$$z_i = \alpha_1 \mathrm{Dlocality} + \alpha_2 \mathrm{age_i} + \alpha_3 \mathrm{educ_i} + \alpha_4 \mathrm{Dpartner_i} + \alpha_5 \mathrm{Dworking_i} + \alpha_6\, \mathrm{cttotal_i} + \alpha_7 \mathrm{hhsize_i} + \alpha_8 \mathrm{housing_i} + \varepsilon_i$$

Where:

*IWB$_{ij}$*: the inner wellbeing of person *i* measured by each of the *j* domains of the IWB model (CR, VM, SC, MH, CSW, EC, PP and SR, with j = 1 to 8). All dependent variables are in a 1 to 5 scale.

*PveQoR$_i$*: the positive interactions with health officers reported by person *i*, in a standardized scale.

*NveQoR$_i$*: the negative interactions with health officers reported by person *i*, in a standardized scale.

*Drole$_i$*: binary (dummy) variable on the role of person i in the programme, where 0 = recipient only and 1 = *vocales* and/or health committee members.

*PveQoR$_i$Drole$_i$*: interaction effect about the impact of PveQoR given the role of person *i in Oportunidades*.

*NveQoR$_i$Drole$_i$*: interaction effect about the impact of NveQoR given the role of person i in *Oportunidades*.

Dlocality$_i$: binary variable of the locality of person i, where 0 = Cualcan and 1 = Nexpan.

*age$_i$*: the age of person *i* measured in years.

*Dpartner$_i$*: binary variable of the marital status of person i, where 0 = no partner (single, divorced, widowed) and 1 = living with partner (married or cohabitating).

*Dworking$_i$*: binary variable about the employment status of person i, where 0 = not working and 1 = working in formal or informal employment.

*cttotal$_i$*: proxy of the amount of cash transfer received by person *i*.

*hhsize$_i$*: household size of person *i*.

*housing$_i$*: quality of dwelling and housing of person *i*.

$\mu_i$ and $\varepsilon_i$: error term of person i for each regression.

$\beta_i$ and $\alpha_j$: the parameters to be estimated in each regression.

*Assumptions*

Assumptions were tested, finding that the residuals of all regressions are homoscedastic (have constant variance) using the Breusch-Pagan/Cook-Weisberg test and no collinearity was present according to the Variance Inflation Factor test that offered a mean coefficient of 1.58 for all models with the highest individual VIF of 2.49. These post-estimation results and the satisfaction of these assumptions justify the interpretation of the results of these regression models following OLS estimation.

*Findings*

The regression analyses presented in table 8.10 indicate that, even after controlling for personal characteristics, positive interactions with health officers (PveQoR) have a significant and positive association with the wellbeing of all recipients for the domains of values and meaning (VM), social connections (SC), economic confidence (EC) and social recognition (SR), as well as for overall happiness.

More specifically, if not capturing endogeneity (see section 8.3.3.1), the positive and significant effect of PveQoR on the recipient's social connections could be due to the fact that as the relationship with health officers improves, people feel more supported by their social networks within their localities. The significant and positive association with economic confidence can be capturing the mediating effect of relationships with officers on the recipients' possibility of securing the cash transfer every two months.

Finally, and importantly, positive interactions with health officers are also significant for increasing the sense of social recognition of participants and decreasing their feelings of not being a capable person in the eyes of others. This is consistent with the previous findings in the qualitative data in which recipients describe how the public humiliation, yelling and threats of the doctors and nurses in the clinic influence their self-esteem and sense of personal worth.

Interestingly, the NveQoR indicator in isolation was not significant for any wellbeing indicator. This is at odds with the qualitative findings that showed that recipients gave a much greater importance to negative interactions with officers on their wellbeing experiences. Despite this incongruity, NveQoR was significant for close relationships (CR), social recognition (SR) and life satisfaction when interacting with the role of

recipients in the programme. This interaction variable evaluates to what extent having a role in *Oportunidades* mediates the effect of the relationship on wellbeing.

**Table 8.10** Regressions IWBi over QoR

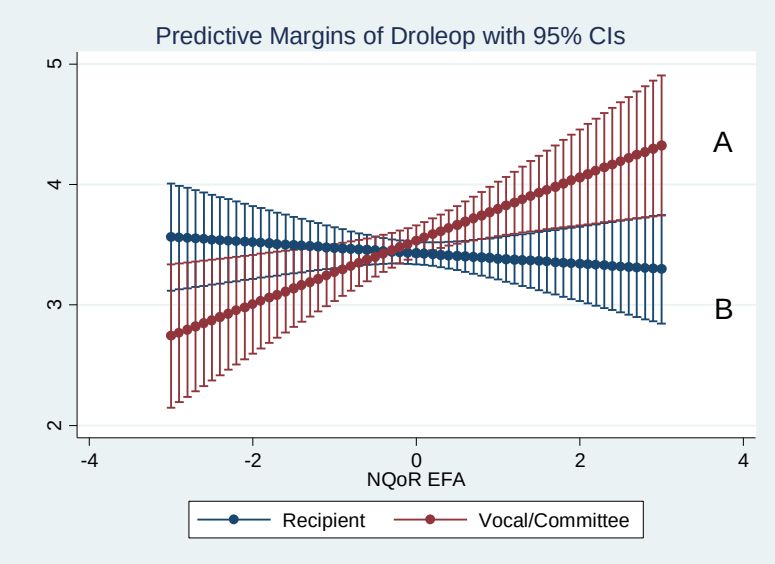
| | CR | VM | SC | MH | CSW | AP | EC | SR | Happiness | Life Satisfaction |
|---|---|---|---|---|---|---|---|---|---|---|
| Relations with officers | | | | | | | | | | |
| PveQoR | .117 | .195** | .170** | .005 | .075 | .055 | .198** | .121* | .238** | .125 |
| | [.093] | [.092] | [.086] | [.066] | [.091] | [.079] | [.078] | [.074] | [.098] | [.098] |
| NveQoR | .107 | -.123 | -.066 | .014 | -.076 | -.073 | -.082 | -.045 | -.108 | -.068 |
| | [.480] | [.093] | [.087] | [.067] | [.092] | [.080] | [.079] | [.074] | [.099] | [.099] |
| Role | .018 | -.024 | -.024 | -.108 | -.022 | .086 | -.052 | .103 | -.147 | .013 |
| | [.094] | [.103] | [.097] | [.074] | [.102] | [.089] | [.088] | [.083] | [.110] | [.110] |
| PveQoR* Role | -.014 | .041 | -.100 | .104 | -.015 | .217* | -.232* | -.207* | -.054 | .288* |
| | [.897] | [.150] | [.141] | [.108] | [.148] | [.129] | [.128] | [.120] | [.160] | [.160] |
| NveQoR* Role | -.284* | .080 | -.115 | .008 | -.106 | -.054 | -.110 | .308** | -.154 | -.308* |
| | [.153] | [.152] | [.142] | [.109] | [.150] | [.131] | [.129] | [.122] | [.162] | [.162] |
| Control Variables | | | | | | | | | | |
| Locality (Nexpan) | .073 | .671*** | -.027 | -.038 | -.082 | -.303*** | .146 | .016 | .383*** | .275** |
| | [.107] | [.106] | [.099] | [.076] | [.104] | [.091] | [.090] | [.085] | [.113] | [.112] |
| Age | .005 | .002 | .005 | -.002 | -.007 | .005 | -.004 | -.001 | -.008 | -.004 |
| | [.005] | [.004] | [.004] | [.003] | [.004] | [.004] | [.004] | [.004] | [.005] | [.005] |
| Years of education | .036*** | .010 | -.008 | -.001 | -.004 | .022 | .004 | .037*** | .013 | .026* |
| | [.014] | [.014] | [.013] | [.010] | [.014] | [.012] | [.012] | [.011] | [.015] | [.015] |
| Living with partner | .145 | .083 | .169 | .124 | .003 | .140 | .103 | -.094 | .147 | .092 |
| | [.119] | [.118] | [.110] | [.085] | [.117] | [.102] | [.101] | [.095] | [.126] | [.126] |
| Employed | .035 | -.055 | .001 | -.167** | .071 | .264*** | -.056 | -.048 | -.233 | -.010 |
| | [.138] | [.105] | [.099] | [.076] | [.104] | [.091] | [.090] | [.084] | [.112] | [.112] |
| Cash Transfer | .000 | .000 | .000 | .000 | .000 | .000 | .000 | .000 | .000 | .000 |
| | [.000] | [.000] | [.000] | [.000] | [.000] | [.000] | [.000] | [.000] | [.000] | [.000] |
| Household size | .005 | -.012 | -.017 | .079 | -.025 | -.004 | -.012 | -.013 | -.006 | -.019 |
| | [.021] | [.021] | [.019] | [.015] | [.020] | [.018] | [.018] | [.016] | [.022] | [.022] |
| Housing | .660*** | .456** | .244 | -.054 | .314 | .031 | .357* | .237 | .186 | .117 |
| | [.218] | [.215] | [.202] | [.155] | [.213] | [.186] | [.184] | [.173] | [.230] | [.229] |
| Constant | 2.27*** | 2.66*** | 2.63*** | 3.12*** | 3.55*** | 2.64*** | 3.03*** | 3.14*** | 3.44*** | 3.24*** |
| | [.349] | [.345] | [.323] | [.248] | [.341] | [.298] | [.294] | [.277] | [.368] | [.367] |
| R-squared | 0.09 | 0.17 | 0.06 | 0.06 | 0.04 | 0.11 | 0.06 | 0.11 | 0.10 | 0.08 |

Observations: 312

*** p-value < 0.01, ** p-value < 0.05,* p-value < 0.1

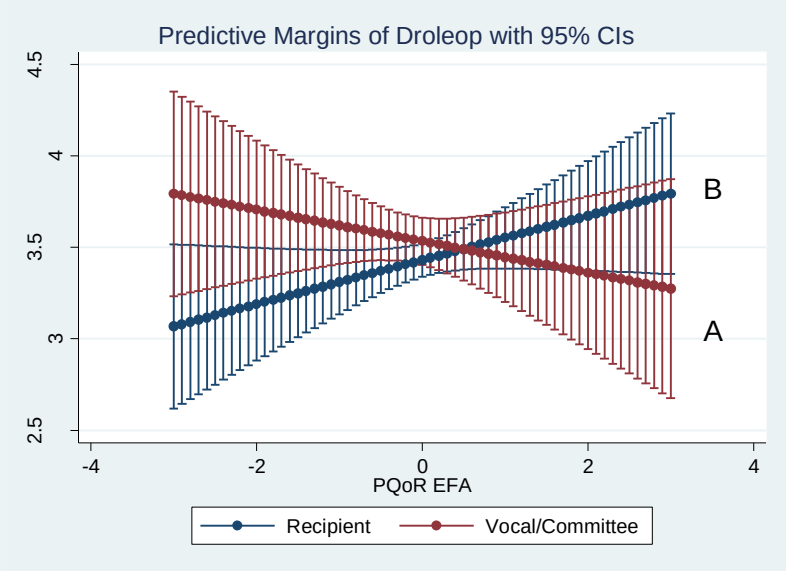
The most interesting result is the positive coefficient (NveQoR*Role=0.308**) of this interaction effect in the domain of Social Recognition (SR), which denotes that for *vocales* and health committee members having negative interactions with officers has a greater effect on how much they feel recognised and valued by others than for an average recipient. This is possibly due to the constant and more frequent interactions these recipients have with officers and the fact that they receive direct orders from them - whether to summon other recipients, collect signatures or reports, or clean the clinic. This is illustrated in the positive slope of the regression curve A for *vocales* and health committee members depicted in figure 8.3.

**Figure 8.2** Predicted scores of Social Recognition (SR) in NveQoR*Role



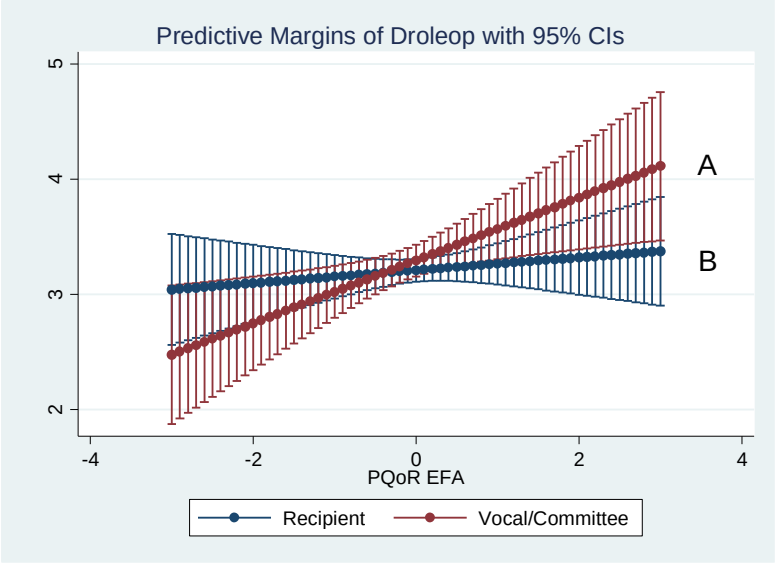

Having a role in *Oportunidades* and the clinic also mediated the effect of the interactions with officers on wellbeing when measured by the positively phrased indicators (PveQoR*Role). On the one hand, the domain of Social Recognition (SR) also exhibited a significant and negative coefficient in this variable (-0.207*). This implies that positive interactions with officers have a lower effect on the social recognition of *vocales* and committee members compared to an average recipient (negative slope of regression curve A in figure 8.4). The double effect of the QoR*Role indicators on SR for recipients with a role indicate that this is probably the domain that is affected the most by the relationship with officers.

**Figure 8.3** Predicted scores of Social Recognition (SR) in PveQoR*Role




On the other hand, the positive coefficient in the domain of Political Participation (PP) (PveQoR*Role=0.217*) indicates that for *vocales* and health committee members having positive interactions with staff had a stronger effect in their sense of political participation and agency than it has for the average recipient (regression curve A in figure 8.5).

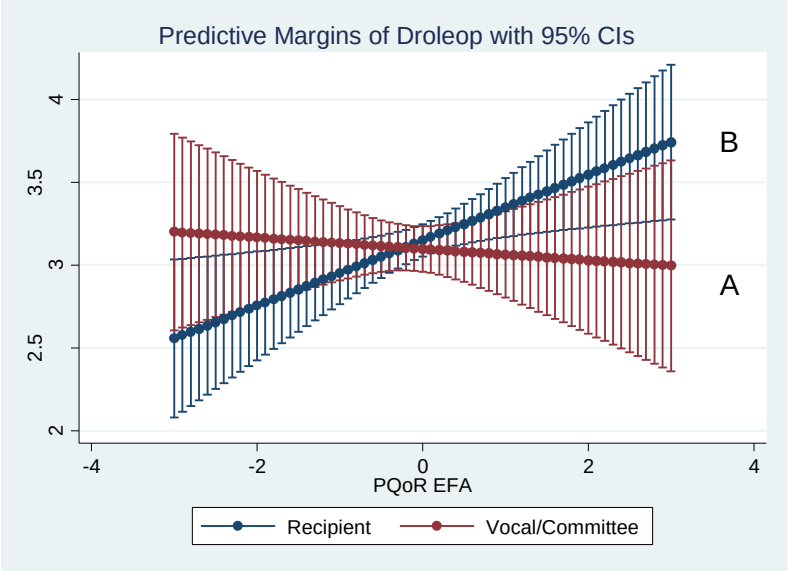
**Figure 8.4** Predicted scores of Political Participation (PP) in PveQoR*Role




Finally, the effect of a positive interaction is less strong for the economic confidence of those with a role than it is for the average recipient (regression curve A figure 8.6).

This result could be related to the reduced knowledge the average recipient has about the power of health officers over their stay in the programme. Additionally, thanks to the training received by *vocales* from *Oportunidades* they are probably better informed about the procedures of the programme and about the role health officers play on them.

**Figure 8.5** Predicted scores of Economic Confidence (EC) in PveQoR*Role




If the R-squared coefficients of these regressions are inspected, it is evident that the explanatory variables are not strong predictors of the wellbeing of recipients in any indicator. In other words, the R-squared coefficients are not very high although they are not smaller than what is usually found in similar studies within the wellbeing literature. It is also important to note that the objective of this analysis was not to maximize the explanation of the determinants of inner wellbeing. Specifically, the objective was to explore the statistical significance of the relationships with health officers in different domains of the inner wellbeing of recipients[88].

[88] Issues of causality are not explicitly investigated here. This dissertation is only exploring the association between the quality of relationships with health officers and the wellbeing of recipients. Nonetheless, it is important to have in mind that a possible reversed causality could exist in which recipients who experience high wellbeing could influence the quality of their relationships with the health officers.

## 8.4 Conclusion

This chapter had the aim of examining the shape of the inner wellbeing and the quality of officer-recipient relationships and their association from a quantitative perspective.

This analysis showed that, on the one hand, the wellbeing of the *Oportunidades* recipients in this sample was relatively low using SWB and IWB indicators with scores ranging from 3.5 to 2.9. The highest-ranking indicators were happiness, life satisfaction and social recognition, whereas the lowest were mental health, social connections, political participation and economic confidence. There were no significant differences between localities except for the domains of values and meaning and political participation. In terms of the role of *Oportunidades* on the wellbeing of recipients, the only significant finding was that being in the programme for longer was associated with a greater sense of political participation. Surprisingly, the size of the cash transfer was not associated with any indicator of wellbeing.

On the other hand, the data on the quality of officer-recipient relationships suggest that recipients in Nexpan reported significantly higher levels of negative interactions and lower levels of positive interactions than Cualcan. Similarly, recipients who had a role in the programme reported significantly lower positive interactions with health officers compared to recipients who met officers less frequently and only interacted with them as clients. Overall, this is consistent with the qualitative findings. However, the average QoR evaluation was higher than what was expected from the experiences and perspectives of recipients obtained in the qualitative study. As discussed in the chapter, this might have been caused by a number of issues such as social desirability biases, the difficulty of capturing certain aspects of relationships quantitatively, or participants' fear of retaliation from officers, which could have been particularly strong since the surveys were applied within the health clinics.

The most important results to answer the principal research question of this dissertation were obtained from the regression analyses scrutinizing the association between officer-recipient relationships and each domain of the inner wellbeing of this sample. The results indicate that five of the eight domains of inner wellbeing are at play during interactions with officers. These are values and meaning (VM), social connections (SC), economic confidence (EC), political participation (PP) and social recognition (SR). In contrast to the qualitative findings presented in chapter six, these results incorporate the domains of VM and SC and exclude the domain of competence and self-worth (CSW) that was salient in the qualitative results.

As discussed in this chapter and chapter seven, there could be a number of reasons behind the inconsistencies between the qualitative and quantitative findings. However, on the whole, the qualitative and quantitative studies point towards the same direction: programme-engendered relationships such as those created between health officers and recipients in the delivery of the health conditionalities of *Oportunidades* are non-negligible for the wellbeing experiences of recipients. Ultimately, these findings have important implications for wellbeing and relationships research, as well as for policy evaluation. These are discussed in the conclusion of this dissertation.

# 9. Conclusion

## 9.1 Introduction

This dissertation set out to explore the role of relationships with health officers in the wellbeing of the recipients of *Oportunidades-Prospera*, the conditional cash transfer programme in Mexico. The overall goal was to contribute to the understanding of the practical implications of subjective wellbeing for policy design, evaluation and analysis at the front-line level (McGregor et al. 2015, White and Abeyasekera 2014). Relationships generated through policy implementation is a largely neglected area for both mainstream wellbeing and public policy literatures since, the first has primarily focused on close and intimate relationships, while the second has seldom used a wellbeing lens to evaluate social programmes in general. Hence, this dissertation sought to meet these theoretical and empirical gaps by conducting a mixed-method study of the delivery of the health component of *Oportunidades-Prospera*. It specifically answered the following research questions:

1. In which ways can a subjective wellbeing approach contribute to assess and evaluate policy processes?

This main research question was investigated through the subsequent questions:

2. What are the characteristics of officer-recipient relationships in the delivery of the health conditionality of *Oportunidades-Prospera*?
3. What is the shape of the subjective wellbeing of recipients?
4. What is the role of officer-recipient relationships in the subjective wellbeing of recipients?

To answer these questions, chapter two started by bringing together the literatures on wellbeing and public policy. It analysed how wellbeing approaches have been employed in public policy, and particularly, its relevance for assessing the effectiveness of programmes and projects at the practical level. The chapter also identified the different ways in which subjective wellbeing approaches have been used in studying relationships and it advocated for its use in scrutinizing those relationships created during policy implementation. The chapter argued that psychosocial approaches are better suited to explore officer-recipient relationships because they offered a more relational understanding of wellbeing that can observe the complex processes through which relationships influence wellbeing.

Chapter three introduced the context of *Oportunidades-Prospera* in order to describe the general characteristics and processes of implementation placing particular attention to the case of the health component of the programme, the main concern of this dissertation. The chapter started to suggest that officer-recipient relationships have an important role in the implementation processes of the health conditionalities, the outcomes of the programme and most importantly, the wellbeing of recipients. However, these findings were based on very little research, so it was appropriate to see whether they were substantiated by the empirical research carried out under this project. Still, the major argument developed in these two initial chapters was that looking at officer-recipient relationships through a wellbeing lens is necessary if we are to improve the design and evaluation of public policies as well as to understand better the contributions of a wellbeing approach in public policy.

After looking at the state of the literature, chapter four justified the choice of a mixed-methods approach and a critical realist perspective for the better inclusion of a relational approach to wellbeing. Finally, chapters five to eight reported on the empirical analysis conducted in two localities of the state of Puebla in Mexico. It is important to underscore that both the qualitative and quantitative analysis tackled all research questions and the empirical chapters discussed the methodological and conceptual implications of the results.

Therefore, this concluding chapter brings together the findings of the empirical chapters and critically examines them. This chapter is, thus, composed of six sections. The first section summarises the core findings within the four empirical chapters and discusses how together they answer the core research questions by linking them to the broader literature and scrutinising the complementarities and contradictions between the qualitative and quantitative methodologies. Then sections 9.3 and 9.4 discuss the theoretical, methodological and policy-related implications of this dissertation. Section 9.5 then provides some recommendations for future research that are derived from the findings and from the limitations of the empirical study conducted. Finally, the conclusion closes with a general reflection on the overall significance of this study and its main contributions to knowledge.

## 9.2 Discussion of the empirical findings

As mentioned above, this section discusses the empirical findings and how they answered the research questions. It is important to reiterate, however, that this section does not discuss each chapter in isolation. Rather, since all four empirical chapters (and methods) contributed to answering all research questions but were presented separately, the purpose here is to integrate and connect the qualitative and quantitative findings for each research question in the next subsections.

### 9.2.1 The characteristics and quality of officer-recipient relationships

To answer the second research question, the empirical chapters scrutinised the main features of the relationship between officers and recipients during the provision and supervision of the health conditionalities of the programme. This was analysed qualitatively and quantitatively in chapters five, six, seven and eight. Chapter five and six undertook a discourse analysis of the perspectives of health officers and recipients about their roles in the programme, the processes of interaction, and the factors that impinged on them. Chapter seven provided the quantitative analysis of the quality of officer-recipient relationships (QoR) scale that was developed based on the qualitative themes presented in chapter six. Factor analytic procedures helped identifying the underlying constructs of the indicator. Finally, chapter eight analysed the shape of the QoR indicators across the sample, by locality and other demographic characteristics. The results and their implications are considered next.

#### *The characteristics and quality of the officer-recipient relationship: Differences across localities*

One of the most salient findings of this dissertation was the importance given by recipients to the quality of their personal relationship with health officers and their perceived attitudes and behaviours towards them. Indeed, their narratives repeatedly confirmed previous evidence (Merkouris et al. 2004) that what was valued by recipients was not only the officer's professional proficiency or the simple reception of a service. Instead, even though recipients cared much about the quality of the medical care received, they constantly linked it to the way it was provided.

In this respect, chapters five and six exhibited through qualitative data that the quality of officer-recipient relationships were opposites in each locality. In Cualcan (rural and indigenous), although participants recalled negative experiences with former officers, they tended to describe their present interactions more positively, underlining *trust, kindness, empathy, dedication* or *care, respect* and *communication*. In Nexpan, however, negative experiences were routine. Despite these differences, when participants in both localities described a negative interaction, they tended to emphasise aspects like *mistreatment, verbal abuse, personal and public humiliation*. But in Nexpan (semi-rural and non-indigenous) these aspects were more extreme, including *discrimination* and *abuse of power.*

These qualitative results were further confirmed in chapters seven and eight, which described quantitatively the quality of this relationship through the QoR scale. Chapter seven presented the factor analytic procedures employed to construct the QoR scale, confirming the separation of the scale into two constructs: positive (PveQoR) and negative (NveQoR) interactions.

Another salient result was that the average QoR reports were more positive than expected given the qualitative data, yet, they verified the disparity in the experiences across localities. Nexpan reported significantly higher levels of negative interactions (2.2>1.9) and lower levels of positive interactions than Cualcan (3.3<3.8) (see table 8.5). Although with cross-sectional data it was not possible to statistically test whether these results were associated with a lower set-point expectation in Nexpan, in the interviews there was no difference between what people expected or described as a positive and a negative interaction in both localities. Similarly, no significant discrepancies were found in the wellbeing reports of recipients among localities that could suggest different biases in responding to survey questions. Hence, these results could indeed be indicating true differences in the quality of interactions among communities. Nonetheless, these results could be further confirmed in another study using more sophisticated quantitative tools (see section 9.5).

In terms of variances among recipients, this dissertation distinguished two types based on their roles in the programme. Regular recipients on the one hand, and recipients who acted or had acted as *vocales* and/or health committee members on the other. The difference being that the latter had more frequent interactions with the officers. During the analysis of the literature in chapter three, it was hypothesised that these roles could entail a distinctive interaction with officers and different effects of

the relationship on their wellbeing. The quantitative data confirmed both. In the first case, *vocales* and health committee members reported lower positive interactions (3.4) compared to an average recipient (3.6), but there was no difference in negative interactions reports (2.1 for both) (see table 8.6). And as emphasised below, the differentiated relationship also influenced participant's wellbeing differently.

### *Factors mediating the officer-recipient relationship*

The narratives of officers (chapter five) and of recipients (chapter six) in the qualitative data, provided an explanation of the different factors affecting the contrasting results across localities. The salient distinguishing factors were the professional identity of officers and their job title within the clinic and the public health system. These results are consistent with the studies that emphasised the influence of the professional (Mandlik et al. 2014) and institutional (Lipsky 2010) authority granted to health officers in the way they delivered the services, as well as those that underlined issues of power and identity in shaping the officer-recipient relationship (Wood 1985, Schaffer 1985, Eyben 2006, etc.).

Officers' professional identity as experts in health and medical procedures was often used to underline their power and to differentiate themselves from recipients. The category of 'doctor' justified the understanding of officers as knowledgeable and educated, in contrast to recipients who were often conflated into the category of patients, conceived as individuals with little knowledge and backward thinking about medical procedures.

In addition, the officer's job title within the clinic separated them into two large groups, permanent officers who were direct employees of the public health system and temporary officers who primarily constituted medical or nursing interns. These tended to foster two opposite styles of interactions. The first style was a relationship of obedience and hierarchies promoted by the permanent officers who were a majority in Nexpan. This relationship was characterised by hostile verbal descriptions of recipients, authoritarian approaches to policy delivery, control, and disengagement from recipients' needs and circumstances. The second style was characterised by a relationship of reciprocity and empathic authority promoted by temporary officers primarily in Cualcan. These officers exercised their authority not through abuse of power but through communication and mutuality.

Given these contrasting styles, officers were perceived very differently by recipients in both localities and encouraged different kinds of relationships. Yet, although authority was exercised differently, in both localities the directors of the clinic were particularly featured as key figures of authority, ruling over the procedures within the clinic and the supervision of the conditionalities of *Oportunidades-Prospera.*

These differential interactions were also encouraged by the demands of the Health Ministry, the discourse of conditionality of *Oportunidades-Prospera*, and the wider culture of discrimination. Firstly, the discourse of conditionality of the programme granted health officers the authority to monitor and regulate the behaviours of recipients around the formal and informal activities of the programme. This validated a disciplinary relationship in which officers used their discretion to decide how to provide the services and how to control the behaviour of recipients. It also endorsed a view of recipients as a captive population whose responsibility was to comply and behave according to the expectations of the health staff.

Secondly, the contradictory demands of the Health Ministry in the evaluation of the officer's outputs in terms of large procedure quotas and strict deadlines specially pressured permanent officers and not temporary officers because of the nature of their rank. As permanent officers had rising responsibilities in the clinic, they also were increasingly worried about meeting deadlines and quotas. Together, these compelled them to prioritise numbers and outcomes rather than the processes of service delivery, inhibiting any concern for the wellbeing of recipients.

Thirdly, previous evidence indicated that negative interactions in *Oportunidades-Prospera* were especially critical in indigenous and rural localities where reports of discrimination, mistreatment, abuse of power and lower quality of health care were more frequent (Campos 2010, Gutiérrez et al. 2008, Smith-Oka 2014, Escobar Latapí 2000, Agudo Sanchiz 2012). In these research sites, however, neither the setting nor ethnic identity explained the nature of this relationship and the overall differences between localities. Although in Cualcan some recipients did describe rougher encounters with officers when indigenous recipients had difficulties speaking or understanding Spanish.

Nonetheless, the wider culture of discrimination, power and hierarchies prevailing in Mexico (CEEY 2013) did permeate into this interaction through officers' understandings of poverty as a personal trait and reducing recipients to the stereotypical labels of 'lazy', 'uneducated', and the stigmatised view of their

profession, ‘peasants’. In the conversations of officers and during their interactions with recipients, these labels also had the function of reinforcing the power of officers and the powerlessness of recipients, as suggested by the development literature (Wood 1985, Schaffer 1985, Eyben 2006). Similarly, although the interviews with recipients focused on present experiences, they repeatedly recounted past experiences of this kind of treatment with former health officers indicating that these interactions were part of the larger structure of health care provision in Mexico (Lipsky 2010) and not only of the participants of this dissertation.

Finally, this dissertation confirmed what Eyben (2010) noted in the context of development agencies, that the power and hierarchies used during interactions with recipients were also noticeable in interactions between staff themselves. In Nexpan, hierarchical relationships also happened among staff which inhibited nonconforming but subordinate/junior staff (usually temporary officers) from improving or criticising the way services were provided. Moreover, the strong community relations that were more prominent in Cualcan than in Nexpan, were also instrumental for recipient families to counteract negative interactions with officers through social cohesion, community empowerment and ability to organise.

Overall, the qualitative results indicated that relationships at different levels influenced the nature of the interactions between officers and programme participants including relationships between officers themselves, and between officers and the community, the programme’s discourse of conditionality, and the Health Ministry.

### *The implications of the quality of the relationship over the programme’s outcomes*

This study confirmed in chapter six that the quality of the relationship with officers was especially relevant for recipients since it was perceived as a key means for receiving better medical attention and for complying with the conditions of the programme more smoothly. Indeed, the attitudes of the health staff towards the recipients significantly influenced the quality of the workshops and the medical attention provided as part of the programme, and the outlooks recipients had about the programme and the clinic. When interactions were perceived as positive, recipients expressed having more trust in the clinic, being more willing to seek

medical attention there and evaluated the quality of the medical attention received more positively.

In contrast, when interactions were perceived as negative, recipients preferred avoiding certain officers or even minimised their involvement in the clinic. The quantitative data in chapter eight confirmed this since, those who reported not choosing the local clinic as their first option to receive medical attention, also reported significantly lower positive interactions (3.2, versus an average of 3.7 for those who chose the local clinic) and higher negative interactions (2.4, versus an average of 1.9 for those who chose the local clinic) with health officers. This double effect was stronger for Nexpan than for Cualcan (table 8.6 presents the complete results).

Looking for other sources of health care in private physicians or traditional healers was not only potentially harmful for their economic security because of the greater cost of private care, but also for their health given the difficulty of identifying legitimate practitioners. In some cases, this also entailed losing the benefits of the programme if the recipient chose to stop complying with the minimum attendance required. These results have important policy implications since not addressing or discouraging negative officer-recipient interactions could reduce the programme's ability to achieve its primary goals such as improving health, but more importantly to have a positive influence in the overall wellbeing of recipients, as the next section shows.

### 9.2.2 The role of officer-recipient relationships for wellbeing

This section discusses how the qualitative (chapter six) and quantitative (chapters seven and eight) empirical results respond to the third and fourth research questions. In doing so, these chapters showed the shape of the wellbeing of recipients and the differential role of officer-recipient interactions on it. Chapter seven and eight ran the quantitative analysis of wellbeing comparing the relative contribution of two approaches, Subjective Well-being (SWB) and Inner Wellbeing (IWB). Chapter seven focused on the construction of the IWB model using factor analysis. Meanwhile, chapter eight performed the descriptive analysis of wellbeing across the sample, as well as correlation and regression analyses to scrutinize the association between IWB and SWB, and between officer-recipient relationships with each domain of IWB. Regarding the qualitative analysis, chapter six undertook a discourse analysis of how

recipients narrated their encounters with health officers and their consequences on their inner wellbeing.

In broad terms, the results of both approaches and methodologies corroborated each other, although the qualitative data uncovered different forms of association that were not observed through the quantitative data. This section discusses these findings together, analysing some of the similarities between them and the causes behind their differences.

### *The shape of the wellbeing of Oportunidades-Prospera recipients in Nexpan and Cualcan*

This dissertation used the SWB and IWB approaches to explore the wellbeing of recipients (chapters seven and eight). The IWB model was adapted to the Mexican sites of Nexpan and Cualcan based on the qualitative enquiry and the use of both exploratory and confirmatory factor analysis to investigate the configuration of the domains. This followed the contextual approach advocated by the Wellbeing and Poverty Pathways research project (2013). Because of this procedure, the shape of the IWB model in this sample was not identical to the original model. The resulting domains were eight, close relationships (CR), values and meaning (VM), social connections (SC), mental health (MH), competence and self-worth (CSW), social recognition (SR), political participation (PP) and economic confidence (EC). Despite this discrepancy, the descriptive and inferential analysis confirmed that using the multidimensional model of IWB permitted obtaining a richer picture of wellbeing, which was then used to analyse the impact of officer-recipient relationships on participant's wellbeing.

The SWB indicators suggested that the recipients' average scores of happiness and life satisfaction (Cualcan: 3.3 and 3.4 respectively; Nexpan: 3.6 in both indicators) were lower than the average levels nation-wide reported by the Mexican statistics office in 2012 (4 and 4.2 respectively), and that Cualcan reported lower levels in both indicators compared to Nexpan (see table 8.1). Yet, these global measures do not allow us to identify the sources of these scores and whether they expressed similar experiences in different domains of life. In contrast, the IWB model shows that this difference was not consistent across all domains since both localities reported similar average levels across all domains except two. Specifically, Cualcan reported

significantly higher political participation (PP) (3.4 versus 3.1 in Nexpan) and Nexpan significantly higher levels of values and meaning (VM) (3.7 versus 3.1 in Cualcan).

Being able to disaggregate in different domains through the IWB model also permitted observing other relationships with demographic variables. While the SWB indicators only suggested that the happiest and most satisfied participants were the younger and more educated, the IWB model showed that other demographic variables were associated with certain domains and not others. For example, being educated was associated with a higher sense of social recognition and better quality of close relationships; while better housing conditions was associated with higher economic confidence, quality of close relationships, and a general sense of meaning in life.

The former results revealed that SWB and IWB do not always concur, hence, it was decided to clarify the empirical association between them through correlation and regression analysis. This exploration has only been done once before (Fernandez et al. 2014), hence there is little knowledge of the association between a psychosocial and a hedonic approach to wellbeing. In this sample, a significant but moderate association between the IWB domains and the global questions of happiness and life satisfaction was found. While the domains of close relationships, economic confidence and values and meaning explained the variation of happiness and life satisfaction, the domains of competence and self-worth, social recognition and political participation did not (tables 8.3 and 8.4). Although the added contribution of the latter domains was justified by the qualitative analysis of the wellbeing of recipients in this sample, it was argued in chapter eight that these quantitative results expose possible conceptual and methodological differences between the two approaches in this sample that should be further investigated. For example, it is likely that in this study people understood happiness and life satisfaction more in relation to immediate circumstances such as their family and their economic hardships; whereas political participation, social recognition and competence and self-worth were secondary aspects for SWB in their circumstances. Yet, this does not imply that these domains are not relevant for their experiences of a good life, as the qualitative data showed.

*The significance of Oportunidades-Prospera in the IWB of recipients*

The qualitative and quantitative studies showed different results concerning the importance of the *Oportunidades-Prospera* programme for the wellbeing of recipients.

The qualitative data supported the fact that the benefits and services of the programme – its cash transfer, medical attention and the knowledge obtained through the health workshops – were essential for the wellbeing of recipients, confirming previous results (Molyneux 2006, Adato 2000). Participants particularly described how the benefits contributed to reducing the shame associated with their poverty and increased their sense of competence, self-worth and overall happiness. However, it was not the size of the cash transfer that was important for wellbeing since it was usually insufficient for sustaining all their needs (chapter six). In fact, the amount of cash transfer received was not significant for any domain of IWB in the regression analyses (chapter eight, table 8.10). Instead, the qualitative data suggested that it was the certainty of receiving a benefit that made it important, as it constituted a safety net for recipient families to buy material assets and to boost their subjective and relational wellbeing.

The amount of time a participant had been a member of the programme also received mixed results in terms of its implications for the wellbeing scores of participants. The quantitative analysis in chapter eight did not show any statistical association between length of participation in the programme and happiness or life satisfaction. However, scores for the IWB domain reflecting participants' sense of their political participation did increase with the years of being recipient. That is, as recipients remained longer in the programme, they felt that they were more capable of voicing their opinions in different social contexts.

Finally, the qualitative results also suggested that the programme had contradictory consequences on the personal relationships of recipients, as featured by previous research (Molyneux 2006). One the one hand, the interviews with recipients confirmed the rise in tensions between the personal responsibilities of female recipients to their families and their duties to the programme. On the other hand, because of the constant interactions with fellow recipients during health workshops and other activities, the programme helped boost the social connectedness of all recipients, especially in the case of *vocales* (Adato 2000).

*Inner wellbeing and the relationship between officers and recipients*

The role of officer-recipient interactions in the inner wellbeing of recipients was explored qualitatively and quantitatively in chapters six and eight. Here these two forms of analysis are presented together to examine how they illuminate each other.

A key contribution of this dissertation was its ability to quantify the association between officer-recipient interactions and different dimensions of wellbeing. This involved two distinct achievements. First, the generation of both positive (PveQoR) and negative (NveQoR) indicators permitted accounting for the negative dimensions of social relationships that are usually excluded from mainstream wellbeing research. Second, this and the multidimensional model of IWB also facilitated accounting for asymmetries in the impact of positive and negative interactions across diverse aspects of wellbeing. This approach contrasts with the dominance of the global questions of SWB which has restricted previous research incorporating this kind of examination[89].

Correlation and regression analysis through OLS and Probit models were conducted to investigate the association between the QoR indicators (PveQoR and NveQoR) and the IWB domains. Significant effects were found for positive (PveQoR) and negative (NveQoR) interactions on different domains of IWB, even after controlling for personal characteristics. As recipients experienced more positive and less negative interactions with health officers, their inner wellbeing improved in different domains. More specifically, for all recipients, having more positive relationships (PveQoR) with officers was significantly associated with greater feelings of connectedness to others in their communities and the quality of that connection (SC) ($p<0.05$), more confidence in managing economically (EC) ($p<0.05$), greater feelings of social recognition (SR) ($p<0.1$), and greater feelings of having a meaningful life overall (VM) ($p<0.05$). In contrast, negative interactions (NveQoR) on their own were not significant for any domain.

An interesting finding was that neither PveQoR nor NveQoR were statistically significant for the domains of mental health (MH) and competence and self-worth (CSW). Although issues of heteroscedasticity in the regression with mental health (MH) advise that these results are interpreted with caution, they could also be pointing to the possibility that this relationship is not relevant given the personal nature of these

[89] One exception comes from the Theory of Self-Determination, see La Guardia and Patrick (2008).

domains. These indicators of IWB are tapping on very personal aspects of wellbeing such as feelings of worry, tension, stress and sadness (MH), and one's ability to help others or to achieve personal goals or tasks (CSW). Therefore, these domains could be explained by other factors and not by this less personal kind of relationship. Indeed, when recipients talked about these domains in the interviews, they did so in relation to the family context. For example, one of their main source of worry and sadness was the health or wellbeing of family members, while their need to feeling capable of conducting certain tasks was related to issues such as childcare or to feeling competent to the eyes of their children. Yet, this was not explored further in this dissertation but is worth pursuing in future research.

Moreover, when disaggregating by the role the recipient played in the programme (participant or vocal/health committee member), it was observed that certain domains were more associated with the QoR indicators than others (see table 8.10). Compared to the average recipient, for *vocales* and health committee members having positive interactions had greater effects on their sense of political participation (PP) and social recognition (SR) ($p<0.1$), while negative interactions also had greater negative effects on their sense of social recognition (SR) ($p<0.05$). That is, when their relationship with officers was positive, their confidence to voice their opinions was more strongly promoted; but if they experienced negative interactions, their ability to voice opinions and their feelings of personal adequacy and of being recognised by others were more negatively affected *than for the average recipient*.

In contrast, compared to the average recipient, having positive interactions with officers had lesser effects on the economic confidence (EC) of *vocales* and health committee members ($p<0.1$). As seen above, according to qualitative data, an important part of recipients' economic confidence was the certainty of receiving the cash transfer which was closely related to the perceived authority of health officers over recipients' stay in the programme. At the same time, the qualitative findings also suggested that recipients obtained more knowledge about programme procedures and the function (power) of health officers on these through the training they received when becoming a *vocal.* Therefore, the lower impacts of the relationship on this domain for *vocales* could be explained by these results. Indeed, in the interviews several *vocales* mentioned being aware about the limited power of health officers when reflecting about their unfounded threats of expulsion.

The policy implications of these results are notable since while these suggest that the programme could indirectly reduce the impact of negative forms of policy implementation on wellbeing by expanding the available information about the programme procedures to recipients, this alone could only counteract the negative effects on economic confidence but not necessarily on every domain of wellbeing. Indeed, as seen above, despite *vocales* having greater knowledge about the programme, the relationship affected their sense of political participation and social recognition more than for a lay recipient. Therefore, programmes should aim at directly addressing the ways in which officers can manifest their power over recipients during their encounters.

As the quantitative data confirmed that officer-recipient relationships had significant effects on the aforementioned domains of wellbeing, the qualitative data permitted observing the processes through which these associations were produced. The recipients' accounts constantly emphasised the complex interlinkages between their inner wellbeing and this relationship. Although a few times recipients recounted that feeling supported and understood by officers improved their sense of competence and self-worth, negative interactions and feelings of mistreatment, disrespect, shaming and discrimination were more intensely expressed.

These conversations confirmed that, as suggested above, the economic confidence of all recipients (but specially of lay recipients) was highly influenced by negative relationships since the officer's abuses of power caused recipients to perceive that remaining in the programme (and thus receiving the cash transfer) was less determined by their own compliance and more by the officer's discretion to decide when to sign the attendance record or to accept proofs of absence. This generated a constant fear of losing entitlements which reduced the recipients' sense of agency and participation. As the relationship became more hierarchical and disengaged, recipients were less confident about being able to solve any issues about the programme or their health and were discouraged to approach officers or raise their voices when they disagreed about how they were treated or about the procedures in the clinic. Feelings of frustration about their inability to change their recurrent negative encounters with officers were manifest in both localities, but especially in Nexpan.

As mentioned earlier, officers constantly discouraged individual or collective agency or empowerment by differentiating themselves from recipients in terms of various sets

of identities. They tended to describe themselves as professionals and educated, in contrast to recipients who were branded as poor, uneducated, and peasants in their encounters. In turn, the recipients' sense of self-worth and competence was diminished, generating feelings of submissiveness, oppression, devaluation and discrimination. The frequent mention of these experiences exposed the repeated manifestation of these encounters and their weight on the wellbeing of recipients.

These results are in line with the few qualitative studies that have, mostly indirectly, found evidence of the wellbeing consequences of this relationship (Molyneux and Thomson 2011, Agudo Sanchiz 2012, Samuels and Stavropoulou 2016 and Attah et al. 2016). For instance, this study confirmed the claim of Agudo Sanchiz (2012) that the power relations between officers and recipients could reduce the capacity of the programme of promoting the agency, participation and empowerment of recipients. Similarly, Molyneux and Thompson (2011) found in the context of Peru that negative interactions with health officers reduced the sense of self-worth, agency and empowerment of recipients. Samuels and Stavropoulou (2016) also confirmed this using the IWB model in the context of Middle East and Sub-Saharan Africa for the domain of competence and self-worth. To my knowledge, this issue has not been explored quantitatively until now.

However, notwithstanding the consistent findings about the differential roles of positive and negative interactions in wellbeing, the qualitative study also captured the ambivalent nature of relationships. Indeed, sometimes even for recipients themselves it was difficult to classify a relationship in either pole, positive or negative. The qualitative data suggested that sometimes good and bad features coexisted in one relationship or interaction, for example, when the quality of an interaction was perceived as depending on mood or on the persons involved. This finding does not necessarily suggest inconsistencies in people's subjective evaluations of a relationship but tensions that need to be understood and dealt with. The results also corroborated the evidence about the role of power in the course and results of this relationship (e.g. PADHI 2009). In these localities, those recipients that felt more empowered by their role in the programme (*vocales*) or by their social status in their communities or the larger society (men), also expressed having better interactions with officers because of their abilities to negotiate their encounters more assertively.

Whereas more research is necessary, these qualitative findings underscore the value of looking at the dynamics of relationships that are difficult to capture in outcome-

based quantitative indicators. This also points out to the role of the methodologies employed which is discussed below. The point so far is that, indeed, the practices and relational processes that occurred during service provision show that as recipients enter *Oportunidades-Prospera*, their experience of wellbeing is also implicitly negotiated during interactions with officers.

## 9.3 Theoretical, methodological and policy implications

The overall contribution of this dissertation is connecting two large research areas, wellbeing and public policy, to explore programme-engendered relationships through a mixed-methods perspective and a critical realist stance. This permitted integrating new claims to each literature at different levels. This section thus summarises the theoretical contributions that emerge from the findings discussed previously, as well as the methodological implications.

The first claim is directed to the wellbeing literature, by emphasising the need to take a broader outlook towards relationships and wellbeing to better understand their intricate association (section 9.3.1). The second is related to the methodological approach taken, the benefits of mixed-methods and critical realism for uncovering the complex connections between inner wellbeing and officer-recipient relationships, and some reflections about the challenges for interaction (section 9.3.2). The third is about the value of a wellbeing lens in public policy design, implementation and evaluation, by showing the contribution of incorporating the assessment of the relationships created during policy implementation and their role on the wellbeing of recipients (section 9.3.3). These original contributions to knowledge have implications for both wellbeing and public policy literatures that are discussed below.

### 9.3.1 The need for a broader outlook towards relationships and wellbeing

This dissertation has contributed to the wellbeing literature by conceptually and empirically demonstrating that a broader outlook towards relationships and wellbeing could uncover important associations between them that are usually unaccounted for by traditional approaches. As discussed in chapter two, while all wellbeing approaches recognise the importance of relationships, mainstream research has

mainly concentrated on the wellbeing outcomes of close relationships. It has also tended to assume that relationships are positive for wellbeing, failing to admit more complex and ambivalent forms of association. This has limited its ability to recognise the full impact of social relationships. Hence, this dissertation took a broader view by, firstly, evaluating the importance of relationships created by public policies during programme implementation, and secondly, using a psychosocial and multi-domain approach to wellbeing and mixing methodologies for this task.

As discussed in the previous section, this permitted observing two forms of association between wellbeing and officer-recipient relationships: (1) the outcomes of the quality of the interaction on different domains of wellbeing; and (2) some processes through which they co-constructed the wellbeing experiences of recipients.

In relation to the first point, rather than solely assessing whether relationships had an effect on an overall measure of subjective wellbeing as mainstream approaches usually do, this dissertation traced which domains were at play during officer-recipient interactions. This demonstrated that relationships can indeed support or thwart certain aspects of wellbeing more than others depending on the type of relationship, the personal characteristics of the actors involved, and on whether positive and negative features of the relationship arise during interactions. Thus, future research should try to decompose its analysis to better understand the pathways through which relationships can transform wellbeing.

In addition to analysing the impact of relationships in different domains of subjective wellbeing separately, this dissertation confirmed that distinguishing between positive and negative aspects of relationships was useful to observe that not all domains of inner wellbeing are similarly influenced by positive and negative encounters. Therefore, simply assessing the amount of social contact people have or the positive aspects of relationships, as SWB tends to do, is not enough to capture the complex interrelationships between social interactions and wellbeing.

In relation to the second point, qualitative analysis of officer-recipient relationship illuminated not just the outcomes but also some of the processes that underlie this association. It uncovered the institutional and cultural factors as well as the power dynamics that mediated the quality of officer-recipient relationships and thus the ability of recipients to experience and to promote their wellbeing during programme encounters within the health clinics of *Oportunidades-Prospera*. These results ultimately indicate that relationships should not be understood as static external

effects on an individually construed wellbeing, but as dynamically and intricately linked to different aspects of wellbeing, as proposed by the development and psychosocial wellbeing literature.

### 9.3.2 Methodological contributions

The mixed-methods and critical realist approach taken by this dissertation offered a number of benefits for this study and important lessons for wellbeing and mixed-methods research.

Firstly, this dissertation advanced from the conventional studies that either take a quantitative or qualitative approach by employing a mixed-method perspective. Quantitative methods enabled this study to speak in a language that is common for policy-makers and mainstream wellbeing literature, while qualitative methods and locally generated indicators permitted observing wellbeing and social relationships through the voice, perspectives and experiences of the participants of this study. Mixing the two narrowed the distance between research, policy-making and the actual experiences programme participants have of both on the ground. In the long run, this could simplify the translation of these (and future) research findings into practical changes in the design and implementation of social programmes, changes that could be more effective as they are built over the experiences of recipients themselves.

Secondly, taking a critical realist perspective permitted being congruent with the understanding of subjective wellbeing taken by this dissertation, one that places relationships at the centre and rejects any individualistic understanding of the construction of wellbeing and subjectivity. It also allowed constant reflection about the way each method illuminated the association between relationships and wellbeing. As mentioned earlier, mixing methods allowed this dissertation to conclude that officer-recipient relationships are not only static impacts on wellbeing but rather this relationship is also vulnerable to the larger political and cultural contexts in which they develop. This more complex understanding of relationships and wellbeing would have been hard to obtain using only quantitative or qualitative methodologies.

However, mixing methodologies should be more than simply recognising the contributions of each method, enabling a dialogue between the different shapes that relationships and wellbeing take when looked at from the unique lenses each

methodology offers. This dissertation tried to do so by identifying, throughout the analysis of the findings, the tensions in mixing methodologies and of transforming qualitative constructs into quantitative indicators, as well as the contradictions and paths for communication between the findings of each.

For instance, this permitted identifying contradictions in the way recipients evaluated the relationship with officers in the interviews and the surveys. In this dissertation, although the items were constructed with the wording recipients used to describe their interactions in the qualitative study, the results suggested that participants tended to evaluate relationships more positively in the surveys than the interviews, and that relationships were better evaluated when answering to positively phrased survey questions than to negatively phrased.

This methodological concern about the presence of biases in the quantitative assessment of relationships has been raised by previous researchers (Simmons and Elias 1994, Merkouris et al. 2004, White and Jha 2014, Jha and White 2015) and can complicate the interpretation of the results. For example, it is yet unclear whether the two underlying constructs in the QoR scale (PveQoR and NveQoR) are capturing different features of relationships as it has been argued in previous research (e.g. Goswami 2011) or whether they simply reflect response biases towards positively and negatively worded questions. The scale, however, was developed through people's own understandings of the quality of their interactions with health officers and proved to be statistically valid according to the factor analytic (FA) procedures.

However, another issue identified arises from the transformation of qualitative constructs found in psychosocial wellbeing studies into quantitative indicators that are analysed through statistical tools like factor analysis (FA). The original IWB model is a complex approach as it tries to capture multiple aspects of each domain at the individual and relational levels, rather than simply measuring the same construct with different wording as is usually done. This is the added contribution of the proposal made by White and colleagues (e.g. 2014) who try to capture those relational experiences of wellbeing uncovered by psychosocial and development approaches in chapter two. However, for simplistic statistical tools like FA such a heterogeneous model is not easy to grapple with.

This raises the question as to which perspective should be prioritised in mixed-methods research when the languages of qualitative and quantitative methods are not easily reconciled. The former permits observing the complex inter-linkages

between domains and dimensions, while the latter needs to simplify and compartmentalise them to observe the general patterns behind. Mixing methods thus requires an ability to speak across the languages of each methodology to obtain solid quantitative indicators and models according to the terms that statistical tools require without oversimplifying the richness of qualitative data. This is especially relevant in the study of sophisticated social phenomena like wellbeing and relationships, and so it strongly defies the exclusive reliance on statistical techniques in wellbeing research and policy evaluation.

Therefore, without an ample understanding of the terms of each methodology and of the tools to maximise their communication, mixing methods could result in simply applying two different approaches to the study of one phenomenon, rather than prompting deeper discussions about their implications in the results obtained. This is what this dissertation set out to do.

### 9.3.3 The value of a wellbeing lens in public policy in practice

Finally, as discussed in chapter two, most wellbeing research has intended to influence policy at the macro level by assessing the wellbeing of societies as a whole, comparing results across countries and drawing conclusions about possible political and economic factors behind the results. Basically, such studies seek to provide an answer as to which societies are happier and more satisfied with their lives and what are the economic and policy structures that underlie these outcomes. In contrast to this approach, this dissertation sought to contribute to knowledge at the front-line level of policy design, implementation and evaluation (see also McGregor et al. 2015), by focusing on the last link in the process of policy, its delivery and implementation through front-line officers. This was done in two ways.

On the one hand, by evaluating the subjective wellbeing of the recipients of a specific programme (*Oportunidades-Prospera*), this dissertation showed that subjective experiences of policy delivery can affect policy outcomes and effectiveness through recipients' attitudes to attendance, compliance and policy implementation in general. Hence, assessing the subjective wellbeing and the personal experiences of recipients during policy implementation could help detect problems that reduce the efficacy of programme implementation and the overall achievement of original programme objectives.

On the other hand, evaluating the association between wellbeing experiences and the relationships created during policy delivery, demonstrated the significance of the terms and quality of interactions between officers and recipients for policy implementation. Indeed, policy implementation is not only about delivering a service or a benefit effectively, it is about the relational processes through which it is delivered. That is, providing the services of the programme through abuses of power, mistreatment, and public humiliation, or through care, dedication, respect and empathy could have significant differences in the way a programme works.

More importantly, however, this dissertation strongly emphasised that analysing these relationships beyond their effects on programme outcomes is crucial, focusing instead on their capacity to transform the wellbeing of recipients. This directly speaks to public policy literature and evaluations which have been primarily concerned with the effects of this relationship on the adequate provision of welfare and on the achievement of the programme's chief goals. In contrast, this dissertation used a wellbeing lens to argue and empirically show that the relationship between officer and recipient is not only important for achieving the direct aims of the programme, like reducing poverty through improvements of health, nutrition, education and consumption. They are important because these relationships can have wider impacts on the life and wellbeing of those the programme is ultimately trying to benefit, recipients. This is particularly significant for social protection programmes and conditional cash transfers that make their benefits 'conditional' to certain behaviours that are directly monitored by front-line officers. Thus, policy implementation in these types of programmes becomes strongly relational.

Therefore, these findings have significant lessons for policy-making as well, since they demonstrated that despite the numerous evaluations of the *Oportunidades-Prospera* programme that attest positive results in objective terms like health and education, looking at the subjective wellbeing of recipients and the relational processes of implementation unveils important unintended and overlooked consequences over people's lives that need to be more systematically included in policy design, implementation and evaluation.

A practical policy recommendation that can accrue from the results of this dissertation is the need to establish effective accountability mechanism that permit obtaining timely and confidential feedback from the final recipients about the quality of service provision and their experiences during policy implementation. Although clinics at the

research sites offered suggestion boxes, in many cases recipients doubted the confidentiality of their submissions since, from their perspective, it was the health officers themselves who opened and sent them up the system at their discretion. A possible way to avoid this could be by making the role of the *promotores* of the programme more effective in representing the interests of the recipients.

As mentioned in chapter five, p*romotores* are direct employees of the programme, coordinating the implementation of the programme at the front-line level (usually the municipality level) and performing as liaison between the programme and the recipients (*vocales* work closely with them). While the relationship promotor-recipient is interesting in itself and could be object of further research, in light of the results of this dissertation, *promotores* are unsuccessful in identifying issues around the quality of service provision and/or in generating positive changes in it. This could happen for various reasons. One could be for communication flaws between *promotores* and recipients or between *promotores,* programme executives and the health ministry, that thwart the possibility of positive feedback loops. Alternatively, this could happen because *promotores* are not sufficiently independent from the programme and thus do not fully serve as ombudsman, representing the interests of recipients by investigating complaints and trying to resolve them through arbitration or recommendations. Hence, facilitating that *promotores* can perform such a role or including another figure for this purpose could be beneficial.

A second way to reduce inadequate treatment could be by addressing it at the level of the front-line officer. As a participant of this study suggested, offering continuous staff training about how to deal with patients in a respectful way could help generate an implementation environment where mistreatment, abuse of power and discrimination is discouraged. Instead, an environment of respect, communication and the exercise of empathic authority could be promoted. Hence, workshops implemented early in their careers could train staff in dealing with people and not only with bodies, and could seek to prevent any kind of inadequate treatment. This is a central area for improvement in the health services offered as part of the programme, especially since it was found that the quality of the service is closely related to the way it is provided during interactions between front-line officers and recipients. Yet, this sort of staff training could be useful for any type of front-line officer, by making them aware about the circumstances and particular needs of recipients, focusing on reducing issues of discrimination and mistreatment common when there is misinterpretation about the causes of poverty and the behaviours of the poor.

## 9.4 Limitations and recommendations for future research

The scale of the debate about the association between relationships and wellbeing and their role in public policy is extensive and multifaceted. To contribute to it, this research project conducted an innovative analysis by using a psychosocial wellbeing approach and mixed methods in the case of the internationally renowned and the largest CCT in Mexico, *Oportunidades-Prospera*. By doing so, it clarified some important interrogations, but it also raised additional issues that can illuminate future research.

Firstly, the disparity between the original model of IWB and the model constructed for this sample generated questions about the success of the process of contextualization of the indicators to the research sites. Contextualization is a process that seeks to improve the relevance of the indicators used to the contexts in which they are applied. However, in these research contexts this process was not easy to conduct because of the low literacy levels in the sample, as well as issues in the translation of the items to Spanish and because this was the second language for some participants in the indigenous locality. Although more could be said about this, in the future and with more resources and time available, more sophisticated procedures such as cognitive interviewing are recommended (Camfield 2016).

Secondly, given the nature and complexity of the IWB and QoR scales discussed above, the quantitative construction of both scales and the analysis of their association could benefit from more advanced quantitative tools. For instance, to evaluate the internal consistency of the scales, the value added of Structural Equation Modelling (SEM) and Item Response Theory (IRT) models (e.g. Mokken 1997, van Schuur 2011) could be explored as they use a different mathematical algorithm to capture the common variation in categorical variables like those that comprised the IWB and QoR scales.

Similarly, although this dissertation used the established approaches of OLS and Probit regression models to analyse the association between IWB and QoR, more complex econometric instruments could be useful to corroborate the estimations obtained and to control for possible issues of endogeneity in the data. For instance, future research could explore the utility of fixed effects models or include variables that control for personality traits that could influence both the dependent and independent variables (e.g. the way participants generally engage with others can

influence at the same time their wellbeing reports and the way they evaluate the quality of their relationship with officers).

Thirdly, although this research project followed strict methodological procedures, lack of resources and time constraints impeded conducting the surveys outside of the health clinics. This could have increased the risk of biases in the recipients' answers particularly in the section evaluating the quality of their relationship with officers due to anonymity concerns or fear of retaliation from officers. Therefore, the positive responses in the QoR scales could also be partly explained by this. Despite these limitations, this dissertation tried to minimise any biases in the qualitative and quantitative results and analysis by triangulating the information with a mixed-methods approach.

Ultimately, the findings of this research project seek to start a conversation about the centrality of officer-recipient relationships in wellbeing and their possible policy implications. However, to generate a more nuanced understanding more research is needed across localities, contexts and social programmes, as well as with larger and more diverse samples. For example, it would be useful to conduct this study in localities where, in contrast to the research sites of this study, all directors of the clinics are permanent officers, but where still both permanent and temporary health officers are currently employed. This, to corroborate the function of the job position in the quality of the interaction. Similarly, gender could be an important explanatory factor of the association between this relationship and wellbeing. Unfortunately, differences based on gender identity were not properly investigated here primarily because of the programme's central focus on female recipients that resulted in men being a minor proportion of the sample, but also because in the research localities all health officers were female at the time. Lastly, future research in other types of social programmes such as those addressed to education and micro-finance could corroborate these results for other types of officer-recipient relationships.

## 9.5 Conclusion

Wellbeing has taught us that how people feel and perceive matters and thus that a subjective approach is a useful framework for public policy. The findings of this dissertation have contributed to this area of enquiry, particularly to the rising discussion about the practical utility of wellbeing in orienting and evaluating policy.

These attest that feeling well, healthy, and less poor does not follow from simply becoming a recipient of a social programme, it is something that is highly mediated by the relationships created during policy implementation and whether they challenge or enlarge the structural and relational processes that keep people in vulnerable situations.

A system that does not address hierarchical and power-heavy interactions, can transform potentially wellbeing-enhancing initiatives into instruments that diminish wellbeing. This dissertation thus advocated for the incorporation of a subjective and relational understanding of wellbeing and policy to uncover programme processes and unintended effects that are usually unaccounted for. This needs to go past an analysis of programme procedures and efficiency and of the resources recipients can have and use, evaluations need to be also about how recipients feel about what they can do and be through the subjective and relational impacts of service provision.

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# Appendix A. Consent forms

**Informed consent health officers:**

My name is Viviana Ramirez. I am a doctorate student in Social Policy at the University of Bath in England. This study is part of the requirements of my thesis. ***The purpose of this interview is to get to know more about your opinion about how the Oportunidades programme works in this locality and your role in its implementation***. The interview will involve a personal conversation that is strictly confidential and that will last approximately 45 minutes.

This is to obtain your consent and inform you as participant of the study that the interview will be recorded only for analysis purposes but your identity will be kept in anonymity at all times. You will be invited to share personal and confidential information during the interview. However, if you decide not to answer any question, we can proceed to the next without needing to provide a reason. You also have the right to stop the interview at any time if you wish to.

If you have any comments or questions you can ask at any time or contact me through the following means:

E-mail: V.R.Ramirez@bath.ac.uk
Mobile No.: ##########

I declare that I have read the information presented in this document and that I accept to voluntarily participate in this research project.

Name: _____
Age: _____
Date: _____/_____/_____

Signature: _____

**Informed consent recipients:**

My name is Viviana Ramirez. I am a doctorate student in Social Policy at the University of Bath in England. This study is part of the requirements of my thesis. ***The purpose of this interview is to get to know more about your experiences in the Oportunidades programme and how it has influenced your wellbeing.*** The interview will involve a personal conversation that is strictly confidential and that will last approximately 45 minutes.

This is to obtain your consent and inform you as participant of the study that the interview will be recorded only for analysis purposes but your identity will be kept in anonymity at all times. You will be invited to share personal and confidential information during the interview. However, if you decide not to answer any question, we can proceed to the next without needing to provide a reason. You also have the right to stop the interview at any time if you wish to.

If you have any comments or questions you can ask at any time or contact me through the following means:

E-mail: V.R.Ramirez@bath.ac.uk
Mobile No.: ##########

I declare that I have read the information presented in this document and that I accept to voluntarily participate in this research project.

Name: _____

Age: _____

Date: _____/_____/_____

Signature: _____

# Appendix B. Interview guide: Health officers

## Semi-structured interview guide: Health Officers

Informed consent explaining the aims of the research and the interview, the duration of the interview, their rights to withdraw and not respond questions, as well as their rights of confidentiality and anonymity. Obtain consent to record the interview.

Pseudonym: _____
Age: _____
Time/Date: _____
Signature: _____

**Opening statement**:

I would like to know and understand better how are the health conditionalities of Oportunidades implemented in this clinic and what have been your experiences working at the clinic.

**Follow-up questions**:

1. How long have you been working in this clinic?
2. What is your main role in the clinic?
3. What has been your experience in the time that you have worked here? What have you liked and what haven't you liked?
4. How are you involved in Oportunidades? What is your role? What things do you like and what don't you like about your involvement in the programme?
5. Could you about your perspective of how the programme works in this clinic?
6. Which do you think are the strengths of the clinic in the way the programme is handled?
7. Which do you think are the challenges or difficulties that the clinic faces in terms of the functioning of the programme?
8. How would you describe the relationship between the health officers and the recipients? And with the vocales?
9. Tell me what happens in a routine consultation with an Oportunidades recipient?
10. What do you think is the attitude of recipients towards the programme and towards complying with the conditionalities?
11. Can you narrate any incident that has happened with a recipient and your perspective of what was the problem?
12. How does the cleaning committee works? What are their responsibilities?

**Concluding question**:

Would you like to add anything that we have not talked about yet?

# Appendix C. Interview guide: Recipients

## Semi-structured interview guide: Recipients

Informed consent explaining the aims of the research and the interview, the duration of the interview, their rights to withdraw and not respond questions, as well as their rights of confidentiality and anonymity. Obtain consent to record the interview.

Pseudonym: _____
Age: _____
Time/Date: _____
Signature: _____

**Opening statement:**

One of the objectives of this interview is to understand how Oportunidades has been significant in your life and what have been your experiences in the clinic.

**Follow-up questions:**

1. You have been recipient of Oportunidades for how long?
2. How do you feel when complying with the health conditions of the programme?
3. Tell me what happens in a routine consultation in the clinic? How does it work? What things do you like or don't like about it?
4. Tell me what happens during the health workshops? What things do you like or don't like about them?
5. Have you been part of the cleaning committee in the clinic? How has been your experience in it?
6. If she is or has been a *vocal*: What does it entail to be a *vocal*? What activities do you engage in? Does any of your work as vocal involve interacting with the health officers? What do you like/don't like about being a *vocal*?
7. How do you get along with the health officers in the clinic?
8. Thinking about your general experience, could you tell me about what are the positive and negative aspects of being a recipient of Oportunidades?
9. In what ways do you think that your relationship with the health officers is important for you or not?

**Concluding question**:

Would you like to add something that you consider important that we have not talked about?

# Appendix D. Focus group guide

## Focus group guide: Recipients

Introduction to the group discussion, the objectives of the meeting, and their rights as participants (anonymity, confidentiality and right to withdraw or not respond).

Setting the guidelines for the discussion: discuss among themselves, respect other's opinions but feel free to agree or disagree with them, commit to not disclose any opinion or theme discussed during the meeting with outside people.

Present myself and ask each participant to present herself:

- Name
- Time in Oportunidades
- Type of recipient: Vocal, health committee member or recipient.

### 1. Drama enactment:

In pairs design and enact a scene were you represent what happens when you interact with the health staff at the local clinic. One should act as the recipient and the other as the officer. Each pair should only make one scene that shows either a negative interaction or a positive interaction between the main actors. How would you describe a negative or positive interaction with a health officer? You can use your previous experiences or the experiences of people you know as input for developing the scene.

***Questions for the whole group after each play:***

a) What stroke you from the scenes of the other groups?
b) What made this particular scene a negative or a positive interaction?
c) Why do you think the officer/recipient had that attitude or reacted in such a way?
d) Anyone remembers a similar experience with the health officers?
e) Does anyone agree or disagree?

### 2. Quality of officer-recipient relationship:

Please reflect on what a negative and a positive relationship with officers is to you? How would you characterise these two types of interaction? Then, in a piece of paper please write down three words to describe each type and place them on the floor.

***Questions for the whole group after all papers are on the floor:***

- What each word means? How would you exemplify it?
- Do agree or disagree? Why?

**Follow-up activity**: Separate the papers describing positive and negative interactions into two columns. Then rank the characteristics of a positive interaction in terms of which is more important and which is less important. Do the same thing for the negative interaction column.

- Do you agree or disagree? Why?

**4. Conclusion:**

Please help me summarise the main themes that surged during the discussion. In what themes do you agree or disagree? Which are the most important?

# Appendix E. Sample survey

## English Version

### Quantitative Survey on Oportunidades and wellbeing of recipients

This survey is part of a doctorate thesis from the University of Bath. This research is completely independent to Oportunidades and the health clinic.

The survey has the objective of knowing about the role of Oportunidades in your wellbeing. It is important that you remember that no personal data will be given and thus your identity will be kept anonymous and that what you respond here will be completely confidential.

**How to respond the survey**: Strike the option that best expresses your opinion. There are no wrong or right answers, just different points of views and feelings. Answer according to what makes sense to you (what you feel and think, and your experiences). Please try to answer all questions without leaving any blank.

Thank you!

**We will start by asking some questions about yourself:**

**1. Sex** ☐ Female ☐ Male

**2. Age** _____

**3. Marital Status**

1 ☐ Living with partner
2 ☐ Married
3 ☐ Widowed
4 ☐ Divorced or Separated
5 ☐ Single (never married)

**4. Education: Highest year of education completed:** _____

**5. Do you speak an indigenous language?** ☐ Yes ☐ No

**6. What is your religion?**

1 ☐ Catholic
2 ☐ Other (which one?) _____
3 ☐ None

**7. Generally, do you work or perform any activity that provides you with an income?** ☐ Yes ☐ No

**Now we will ask you about YOUR WELLBEING:**

| | | | | | | |
|---|---|---|---|---|---|---|
| **GW 1** | **In general, how happy would you say you are?** | Very unhappy | Unhappy | Neither happy nor unhappy | Happy | Very happy |
| **GW 2** | **Taking all things together, how satisfied are you with your life as a whole?** | Very unsatisfied | Unsatisfied | Neither satisfied nor unsatisfied | Satisfied | Very satisfied |

**Please answer the following questions with all HONESTY:**

| | **EC** | **1** | **2** | **3** | **4** | **5** |
|---|---|---|---|---|---|---|
| 1 | **How do you feel about your economic situation?** | Very bad | Bad | Somewhat | Good | Very good |
| 2 | **How well could you manage economically if something wrong were to happen (e.g. illness in the family)?** | Very bad | Bad | Somewhat | Good | Very good |
| 3* | **To what extent your economic worries affect your participation in the town celebrations?** | Not at all | Very Little | Somewhat | Quite a bit | A great deal |
| 4* | **Do you feel that people around have done better economically than you?** | Never | Rarely | Sometimes | Usually | Always |
| 5* | **How often do you feel worried about money?** | Never | Rarely | Sometimes | Usually | Always |

| | **AP** | **1** | **2** | **3** | **4** | **5** |
|---|---|---|---|---|---|---|
| 1 | **In a town meeting, do you feel that you can give your opinion freely?** | Never | Rarely | Sometimes | Usually | Always |
| 2 | **If an authority makes a decision that affects you directly, do you feel that you can protest against it?** | Never | Rarely | Sometimes | Usually | Always |
| 3* | **How often do you feel that others do not care about what you have to say?** | Never | Rarely | Sometimes | Usually | Always |
| 4 | **How often can you and your town unite to do something together in favour of your community?** | Never | Rarely | Sometimes | Usually | Always |
| 5 | **How often do you feel that you have the freedom to make your own decisions?** | Never | Rarely | Sometimes | Usually | Always |

| | SC | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| 1 | **If you need something (find a job, talk to an authority) do you have any friends or people you know that knows how to help you?** | None | Very few | A few | Several | Many |
| 2 | **Do you feel that you have friends or acquaintances in which you can count on during difficult times?** | None | Very few | A few | Several | Many |
| 3 | **How often do you feel included in your community?** | Never | Rarely | Sometimes | Usually | Always |
| 4 | **In general, do you feel that people in your community are helpful?** | Not at all | Very Little | Somewhat | Quite a bit | A great deal |
| 5* | **To what extent you feel affected by gossip or what your neighbours and people in your community could say about you?** | Not at all | Very Little | Somewhat | Quite a bit | A great deal |

| | CR | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| 1 | **When you need to talk about something that is important to you, is there someone you can go to?** | Never | Rarely | Sometimes | Usually | Always |
| 2 | **How often do you feel there is harmony in your home?** | Never | Rarely | Sometimes | Usually | Always |
| 3 | **Do you feel that your family cares about you?** | Never | Rarely | Sometimes | Usually | Always |
| 4 | **In general, how often do you feel that your family supports you in the important decisions you make?** | Never | Rarely | Sometimes | Usually | Always |
| 5* | **How worried are you about the amount of violence in your home?** | Not at all | Very Little | Somewhat | Quite a bit | A great deal |
| 6 | **In general, do you like the way that your family treats you?** | Not at all | Very Little | Somewhat | Quite a bit | A great deal |

| | PhMH | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| 1 | **How often do you sleep well?** | Never | Rarely | Sometimes | Usually | Always |
| 2* | **How often do you feel tense or worried?** | Never | Rarely | Sometimes | Usually | Always |
| 3* | **How often do you feel sad?** | Never | Rarely | Sometimes | Usually | Always |
| 4 | **How often do you feel that you have the strength you need for your daily work?** | Never | Rarely | Sometimes | Usually | Always |
| 5* | **In the last months, how much have you worried about your health?** | Not at all | Very Little | Somewhat | Quite a bit | A great deal |

| | CSW | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| 1 | **How capable do you feel of helping others?** | Not at all | Very Little | Somewhat | Quite a bit | A great deal |
| 2 | **In general, how capable do you feel of achieving the things that matter to you?** | Not at all | Very Little | Somewhat | Quite a bit | A great deal |
| 3 | **In general, how good do you feel you are in performing your daily tasks?** | Not at all | Very Little | Somewhat | Quite a bit | A great deal |
| 4* | **How often do people around you make you feel that you are not capable of doing or saying things?** | Never | Rarely | Sometimes | Usually | Always |
| 5* | **How often do you feel as if you were ignorant?** | Never | Rarely | Sometimes | Usually | Always |

| | VM | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| 1 | **Do you feel that life has been good to you?** | Not at all | Very Little | Somewhat | Quite a bit | A great deal |
| 2 | **Do you feel that God is with you?** | Not at all | Very Little | Somewhat | Quite a bit | A great deal |
| 3 | **How often do you feel that your life has been worthwhile?** | Never | Rarely | Sometimes | Usually | Always |
| 4 | **How often do you feel at peace with yourself at the end of the day?** | Never | Rarely | Sometimes | Usually | Always |
| 5 | **How often do you feel that your life is meaningful?** | Never | Rarely | Sometimes | Usually | Always |

**Now we will ask you about the Oportunidades programme:**

**8. For how long have you been a recipient of Oportunidades?** _____

**9. For how many BOYS do you receive scholarships or food support from Oportunidades (If you do not receive support for BOYS, proceed to question 10)** _____

**9a. If you DO receive support for BOYS, please indicate below which school year each of them is currently studying.**

Boy 1: _____
Boy 2: _____
Boy 3: _____
Boy 4: _____

**10. For how many GIRLS do you receive scholarships or food support from Oportunidades (If you do not receive support for GIRLS, proceed to question 11)** _____

**10a. If you DO receive support for GIRLS, please indicate below which school year each of them is currently studying.**

Girl 1: _____

Girl 2: _____

Girl 3: _____

Girl 4: _____

**11. In what ways have you participated in the Oportunidades programme? Choose all that apply to you.**

**1** ☐ Health Committee

**2** ☐ Vocal

**3** ☐ Recipient Only

**4** ☐ Other, which? _____

**12. Do you currently attend the clinic for any of the following reasons? Choose all that apply to you.**

| | | | |
|---|---|---|---|
| 1 ☐ | You are pregnant | 4 ☐ | You suffer from hypertension |
| 2 ☐ | You suffer from Diabetes | 5 ☐ | Family planning |
| 3 ☐ | For weight control or malnourishment | 0 ☐ | None |

| | IR | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| 1 | **How important is for you to have a good relationship with the doctors and nurses in your health clinic?** | Not at all | Very Little | Somewhat | Quite a bit | A great deal |
| 2 | **How important is for you to have a good relationship with your neighbours and people in your community?** | Not at all | Very Little | Somewhat | Quite a bit | A great deal |
| 3 | **How important is for you to have a good relationship with your family?** | Not at all | Very Little | Somewhat | Quite a bit | A great deal |

**Now we will ask you about how it goes when you attend your health clinic:**

When you answer to the following questions, please think about your experience with the doctors and nurses you have interacted with in the local health clinic for the last months (during the consultations and workshops of Oportunidades).

| | | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| 1 | **Do you feel that the way you are asked to comply with the conditions of Oportunidades by doctors/nurses is appropriate?** | Never | Rarely | Sometimes | Usually | Always |
| 2 | **Thinking about your overall experience, do you feel that the doctors/nurses pay attention to what you have to say?** | Never | Rarely | Sometimes | Usually | Always |
| 3 | **Do you feel that the doctors or nurses in the clinic treat you with kindness and respect?** | Never | Rarely | Sometimes | Usually | Always |
| 4 | **Do you feel the doctors or nurses explain things appropriately?** | Never | Rarely | Sometimes | Usually | Always |
| 5* | **Do you feel doctors or nurses abuse of their position?** | Never | Rarely | Sometimes | Usually | Always |
| 6 | **When a doctor or nurse says or does something you do not like, do you feel that you can say or do something about it?** | Never | Rarely | Sometimes | Usually | Always |
| 7* | **Have you felt discriminated during your medical consultations or workshops in the clinic?** | Never | Rarely | Sometimes | Usually | Always |

| | | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| 8* | **Have you felt scolded by a doctor/nurse in front of others?** | Never | Rarely | Sometimes | Usually | Always |
| 9* | **Have you felt insulted or humiliated for any doctor or nurse in the clinic?** | Never | Rarely | Sometimes | Usually | Always |
| 10* | **Do you feel that your privacy is respected by doctors/nurses in the clinic?** | Never | Rarely | Sometimes | Usually | Always |
| 11 | **Do you feel that the waiting time you spend to get a medical consultation is worth the while?** | Never | Rarely | Sometimes | Usually | Always |
| 12 | **When you go to the clinic, do you feel that they give you an adequate medical check-up?** | Never | Rarely | Sometimes | Usually | Always |
| 13 | **Do you feel that the doctors and nurses make an effort to give you the best care?** | Never | Rarely | Sometimes | Usually | Always |
| 14 | **Do you feel that the doctors and nurses in the clinic are sensitive to you and your needs?** | Never | Rarely | Sometimes | Usually | Always |

| | GQ | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| 15 | **How important is to you to receive a good medical attention in the health clinic?** | Never | Rarely | Sometimes | Usually | Always |
| 16 | **How important is to you, NOT being mistreated in the health clinic?** | Never | Rarely | Sometimes | Usually | Always |
| 17 | **If you could choose, how often would you attend the local clinic if you or a family member were feeling unwell?** | Never | Rarely | Sometimes | Usually | Always |

## Now we will ask you about your FAMILY:

**13. With how many people you live in your house including yourself?** _____

**14. Indicate the number of children that you have in total:** _____

**15. Your or any person that lives or lived with you moved to the USA?** ☐ Yes ☐ No

## Now we would like to talk about your HEALTH:

**16. If you or any family member were ill, which would be the first place you would go for help?**

1 ☐ Traditional healer
2 ☐ Private Physician
3 ☐ Health Clinic
4 ☐ Public Hospital
5 ☐ Private Hospital
6 ☐ Other (which?) _____

**17. Thinking about your general experience, how satisfied are you with the health services you receive in the local health clinic?**

1 ☐ Not at all satisfied
2 ☐ Little satisfied
3 ☐ Somewhat satisfied
4 ☐ Satisfied
5 ☐ Very satisfied

**18. What are your dislikes about the health services that you receive from the local health clinic? You can select more than one option.**

1 ☐ Distance from home
2 ☐ Quality of treatment from staff
3 ☐ Lack of medicine availability
4 ☐ Economic costs
5 ☐ Quality of staff
6 ☐ Waiting time
7 ☐ Other _____

**Finally we will ask you about how are you doing ECONOMICALLY:**

**19. Indicate if you have any of the following assets in your household:**

1 ☐ Chicken, turkeys
2 ☐ Horses, Cows, Pigs
3 ☐ Latrine
4 ☐ Toilet
5 ☐ Radio
6 ☐ Television
7 ☐ Mobile Phone
8 ☐ Land-line
9 ☐ Electric or Gas Cooker
10 ☐ Refrigerator
11 ☐ Washing machine
12 ☐ Computer
13 ☐ Bicycle
14 ☐ Automobile o Truck
15 ☐ Land to cultivate

**20. The water in your household usually comes from:**

1 ☐ Piped into residence
2 ☐ Piped from neighbour/other
3 ☐ No piped water (e.g. well, river)

**21. The fuel that you usually use for cooking is?**

1 ☐ Coal
2 ☐ Wood
3 ☐ Gas or Electricity

**22. What material are most of the WALLS of your house made of?**

1 ☐ Junk
2 ☐ Cardboard Sheet
3 ☐ Metallic Sheet
4 ☐ Asbestos Sheet
5 ☐ Bamboo
6 ☐ Wood
7 ☐ Block, brick, concrete.

**23. What material is most of the FLOOR of your house made of?**

1 ☐ Earth
2 ☐ Cement
3 ☐ Tiles, polished wood, other

**24. What material is the most of the CEILING of your house made of?**

1 ☐ Junk
2 ☐ Cardboard Sheet
3 ☐ Metallic Sheet
4 ☐ Asbestos Sheet
5 ☐ Block, brick
6 ☐ Tiles, wood

**25. How have you been doing economically for the past year?**

1 ☐ Very bad
2 ☐ Bad
3 ☐ Neither bad nor good
4 ☐ Good
5 ☐ Very good

**26. How you are doing economically today compared to how you were doing before you received Oportunidades?**

1 ☐ Much worse
2 ☐ Worse
3 ☐ The same
4 ☐ Better
5 ☐ Much better

## Spanish Version

Este cuestionario tiene la finalidad de conocer sobre el papel del programa Oportunidades en tu vida. Este estudio es parte de una tesis doctoral de la Universidad de Bath en el Reino Unido, y es completamente independiente del programa Oportunidades y de la clínica de salud. Es importante que recuerdes que tu identidad será anónima en todo momento y que lo que contestes aquí será totalmente confidencial.

**Como responder el cuestionario**: Pon tu respuesta tachando la opción que mejor exprese tu opinión. Recuerda que no hay respuestas correctas o incorrectas, sólo hay puntos de vista y formas de sentir diferentes. Contesta de acuerdo a lo que tiene sentido para ti (lo que sientes, piensas, o las experiencias que has tenido).

Por favor contesta todas las preguntas sin dejar ninguna en blanco.

¡Gracias! ¡Miak Tasojkamatik!

**<u>Empezaremos haciéndote algunas preguntas sobre ti:</u>**

**1. Sexo** ☐ Femenino ☐ Masculino

**2. Edad (años cumplidos)** _____

**3. Estado Civil**

1 ☐ Unión Libre
2 ☐ Casada(o)
3 ☐ Viuda(o)
4 ☐ Divorciada(o) o Separada(o)
5 ☐ Soltera(o)

**4. Educación: Último grado escolar concluido:** _____

**5. ¿Hablas alguna lengua indígena?** ☐ Si ☐ No

**6. ¿Cuál es tu religión?**

1 ☐ Católica
2 ☐ Otra (¿cuál?) _____
3 ☐ Ninguna

**7. ¿Generalmente trabajas o realizas una actividad que te de un ingreso económico?** ☐ Si ☐ No

**Ahora te preguntaremos sobre TÚ BIENESTAR:**

| | | | | | | |
|---|---|---|---|---|---|---|
| **GW 1** | **En general, ¿qué tan feliz dirías que eres?** | Muy infeliz | Infeliz | Ni infeliz ni feliz | Feliz | Muy feliz |
| **GW 2** | **Tomando todo en cuenta, ¿qué tan satisfecho estás con tu vida?** | Muy insatisfecho | Insatisfecho | Ni satisfecho ni insatisfecho | Satisfecho | Muy satisfecho |

**Por favor contesta las siguientes preguntas con toda sinceridad:**

| | EC | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| 1 | **¿Cómo te sientes en cuanto a tu situación económica?** | Muy mal | Mal | Regular | Bien | Muy bien |
| 2 | **Si algo malo pasara (por ejemplo, una enfermedad en la familia), ¿podrías solventarla económicamente?** | Muy mal | Mal | Regular | Bien | Muy bien |
| 3* | **¿Hasta qué punto tus preocupaciones económicas afectan tu participación en las fiestas del pueblo?** | Nada | Muy poco | Regular | Un tanto si | Mucho |
| 4* | **¿Has sentido que a otros les ha ido mejor económicamente que a ti?** | Nunca | Casi nunca | Algunas veces | Muchas veces | Siempre |
| 5* | **¿Qué tan seguido te sientes preocupado por el dinero?** | Nunca | Casi nunca | Algunas veces | Muchas veces | Siempre |

| | AP | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| 1 | **En una reunión del pueblo, ¿sientes que puedes dar tu opinión libremente?** | Nunca | Casi nunca | Algunas veces | Muchas veces | Siempre |
| 2 | **Si una autoridad toma una decisión que te afecta directamente, ¿sientes que puedes protestar en contra?** | Nunca | Casi nunca | Algunas veces | Muchas veces | Siempre |
| 3* | **¿Qué tan seguido sientes que a los demás NO les importa lo que tienes que decir?** | Nunca | Casi nunca | Algunas veces | Muchas veces | Siempre |
| 4 | **¿Qué tan seguido sientes que puedes unirte con tu pueblo para que juntos hagan algo en favor de su comunidad?** | Nunca | Casi nunca | Algunas veces | Muchas veces | Siempre |
| 5 | **¿Qué tan seguido sientes que NO tienes la libertad de tomar tus propias decisiones sobre las cosas que te importan?** | Nunca | Casi nunca | Algunas veces | Muchas veces | Siempre |

| | SC | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| 1 | **Si necesitas algo (conseguir un trabajo, hablar con alguna autoridad), ¿tienes algún amigo o conocido que pueda ayudarte?** | Ninguno | Muy pocos | Pocos | Varios | Muchos |
| 2 | **¿Tienes amigos o conocidos en los que puedes contar durante momentos difíciles?** | Ninguno | Muy pocos | Pocos | Varios | Muchos |
| 3 | **¿Qué tan seguido sientes que NO eres incluido en tu comunidad?** | Nunca | Casi nunca | Algunas veces | Muchas veces | Siempre |
| 4 | **En general, ¿sientes que la gente en tu comunidad es ayudadora?** | Nunca | Casi nunca | Algunas veces | Muchas veces | Siempre |
| 5* | **¿Qué tanto te afectan los chismes o lo que puedan decir de ti tus vecinos o la gente de tu comunidad?** | Nada | Muy poco | Regular | Un tanto si | Mucho |

| | CR | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| 1 | **¿Hay alguien a quien puedas acudir cuando quieres hablar de algo importante para ti?** | Nunca | Casi nunca | Algunas veces | Muchas veces | Siempre |
| 2 | **¿Qué tan seguido sientes que hay armonía dentro de tu familia?** | Nunca | Casi nunca | Algunas veces | Muchas veces | Siempre |
| 3 | **¿Sientes que tu familia se preocupa y cuida de ti?** | Nunca | Casi nunca | Algunas veces | Muchas veces | Siempre |
| 4 | **En general, ¿qué tan seguido sientes que tu familia te apoya en las decisiones importantes que tomas?** | Nunca | Casi nunca | Algunas veces | Muchas veces | Siempre |
| 5* | **¿Qué tan preocupado estás de la cantidad de violencia que hay en tu casa?** | Nada | Muy poco | Regular | Un tanto si | Mucho |
| 6 | **En general, ¿te gusta la forma en la que tu familia te trata?** | Nada | Muy poco | Regular | Un tanto si | Mucho |

| | PhMH | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| 1 | **¿Qué tan seguido duermes bien?** | Nunca | Casi nunca | Algunas veces | Muchas veces | Siempre |
| 2* | **¿Qué tan seguido te sientes tenso o preocupado?** | Nunca | Casi nunca | Algunas veces | Muchas veces | Siempre |
| 3* | **¿Qué tan seguido te sientes triste?** | Nunca | Casi nunca | Algunas veces | Muchas veces | Siempre |
| 4 | **¿Qué tan seguido sientes que tienes la fuerza que necesitas para hacer tu trabajo diario?** | Nunca | Casi nunca | Algunas veces | Muchas veces | Siempre |
| 5* | **En los últimos meses, ¿qué tanto te ha preocupado tu salud?** | Nada | Muy poco | Regular | Un tanto si | Mucho |

| | CSW | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| 1 | **¿Qué tan capaz te sientes de poder ayudar a otras personas?** | Nada | Muy poco | Regular | Un tanto si | Mucho |
| 2 | **En general, ¿te sientes capaz de lograr las cosas que te importan?** | Nada | Muy poco | Regular | Un tanto si | Mucho |
| 3 | **En general, ¿te sientes bueno para hacer tus labores?** | Nada | Muy poco | Regular | Un tanto si | Mucho |
| 4* | **¿Qué tan seguido otras personas te hacen sentir que NO eres capaz de hacer o decir cosas?** | Nunca | Casi nunca | Algunas veces | Muchas veces | Siempre |
| 5* | **¿Qué tan seguido te sientes como si fueras una persona ignorante?** | Nunca | Casi nunca | Algunas veces | Muchas veces | Siempre |

| | VM | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| 1 | **¿Sientes que la vida ha sido buena contigo?** | Nada | Muy poco | Regular | Un tanto si | Mucho |
| 2 | **¿Sientes que Dios está contigo?** | Nada | Muy poco | Regular | Un tanto si | Mucho |
| 3 | **¿Qué tan seguido sientes que tu vida ha valido la pena?** | Nunca | Casi nunca | Algunas veces | Muchas veces | Siempre |
| 4 | **¿Qué tan seguido te sientes en paz contigo mismo al final del día?** | Nunca | Casi nunca | Algunas veces | Muchas veces | Siempre |
| 5 | **¿Qué tan seguido sientes que tu vida tiene sentido?** | Nunca | Casi nunca | Algunas veces | Muchas veces | Siempre |

**Ahora te preguntaremos sobre el Programa OPORTUNIDADES:**

**8. ¿Cuánto tiempo llevas siendo beneficiaria o titular del programa OPORTUNIDADES?** _____

**9. Para cuántos NIÑOS VARONES recibes beca o apoyo alimenticio de parte del programa Oportunidades (SI no recibes para ningún NIÑO, pasa a la siguiente pregunta)** _____

**9a. Si SÍ recibes apoyo para NIÑOS VARONES, por favor indica abajo en qué grado escolar está cada uno de los de ellos.**

Niño 1: _____
Niño 2: _____
Niño 3: _____
Niño 4: _____

**10. Para cuántas NIÑAS MUJERES recibes beca o apoyo alimenticio de parte del programa Oportunidades (SI no recibes para ninguna NIÑA, pasa a la siguiente pregunta)** _____

**10a. Si SÍ recibes apoyo para NIÑAS MUJERES, por favor indica abajo en qué grado escolar está cada uno de los de ellos.**

Niña 1: _____
Niña 2: _____
Niña 3: _____
Niña 4: _____

**11. ¿De qué formas has participado en el programa Oportunidades? Puedes elegir más de una opción.**

**1** ☐ Comité de salud
**2** ☐ Vocal
**3** ☐ Sólo beneficiaria/o o titular
**4** ☐ Otro, ¿cuál? _____

**12. ¿Actualmente vas a la clínica de salud por alguna de las siguientes razones? Elige todas las que apliquen para ti.**

1 ☐ Estás embarazada
2 ☐ Eres diabético
3 ☐ Por control de peso y talla (desnutrición)
4 ☐ Eres hipertenso
5 ☐ Planificación familiar
0 ☐ Ninguna

| | IR | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| 1 | **¿Qué tan importante es para ti tener una buena relación con los doctores o enfermeras de la clínica?** | Nada | Muy poco | Regular | Un tanto si | Mucho |
| 2 | **¿Qué tan importante es para ti tener una buena relación con los vecinos y la gente de tu comunidad?** | Nada | Muy poco | Regular | Un tanto si | Mucho |
| 3 | **¿Qué tan importante es para ti tener una buena relación con tu <u>familia</u>?** | Nada | Muy poco | Regular | Un tanto si | Mucho |

**Ahora te preguntaremos sobre tus experiencias en la CLÍNICA DE SALUD:**

Cuando respondas estas preguntas por favor piensa en tú experiencia con los doctores y enfermeras que te han atenido en la clínica de salud en los últimos meses (durante las consultas de sano o enfermo, y talleres de Oportunidades).

| | | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| 1 | **¿Sientes que la manera en la que te piden que cumplas con las condiciones del programa Oportunidades es apropiada?** | Nunca | Casi nunca | Algunas veces | Muchas veces | Siempre |
| 2 | **Pensando en tu experiencia en general, ¿Sientes que las doctoras y enfermeras ponen atención a lo que les dices?** | Nunca | Casi nunca | Algunas veces | Muchas veces | Siempre |
| 3 | **¿Sientes que los doctores y enfermeras te tratan con amabilidad y respeto?** | Nunca | Casi nunca | Algunas veces | Muchas veces | Siempre |
| 4 | **Cuando vas a la clínica a tu consulta o taller, ¿sientes que las doctoras y enfermeras te explican bien las cosas?** | Nunca | Casi nunca | Algunas veces | Muchas veces | Siempre |
| 5* | **¿Sientes que los doctores o enfermeras abusan de su puesto?** | Nunca | Casi nunca | Algunas veces | Muchas veces | Siempre |
| 6 | **Cuando un doctor o enfermera dice algo que no te gusta, ¿sientes que puedes decir o hacer algo al respecto?** | Nunca | Casi nunca | Algunas veces | Muchas veces | Siempre |
| **7*** | **¿Te has sentido discriminado durante tus consultas médicas o talleres en la clínica?** | Nunca | Casi nunca | Algunas veces | Muchas veces | Siempre |

| | | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| 8* | **¿Qué tan seguido algún doctor o enfermera te ha regañado enfrente de otros?** | Nunca | Casi nunca | Algunas veces | Muchas veces | Siempre |
| 9* | **¿Te has sentido insultado o humillado por algún doctor o enfermera?** | Nunca | Casi nunca | Algunas veces | Muchas veces | Siempre |
| 10* | **¿Sientes que los doctores y enfermeras respetan tu privacidad?** | Nunca | Casi nunca | Algunas veces | Muchas veces | Siempre |
| 11 | **Cuando vas a tu consulta de enfermo, ¿sientes que el tiempo que tardas en la clínica para ser atendido vale la pena?** | Nunca | Casi nunca | Algunas veces | Muchas veces | Siempre |
| 12 | **¿Sientes que te dan una atención médica adecuada en la clínica?** | Nunca | Casi nunca | Algunas veces | Muchas veces | Siempre |
| 13 | **¿Sientes que los doctores y enfermeras tratan de darte la mejor atención?** | Nunca | Casi nunca | Algunas veces | Muchas veces | Siempre |
| 14 | **¿Sientes que los doctores y enfermeras son sensibles a ti y a tus necesidades?** | Nunca | Casi nunca | Algunas veces | Muchas veces | Siempre |

| | GQ | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| 15 | **¿Qué tan importante es para ti recibir una buena atención médica en la clínica de salud?** | Nunca | Casi nunca | Algunas veces | Muchas veces | Siempre |
| 16 | **¿Qué tan importante es para ti NO recibir maltrato en tu clínica de salud?** | Nunca | Casi nunca | Algunas veces | Muchas veces | Siempre |
| 17 | **Si pudieras escoger, ¿qué tan seguido escogerías ir a tu clínica de salud si tú o algún familiar están enfermos?** | Nunca | Casi nunca | Algunas veces | Muchas veces | Siempre |

## Ahora te preguntaremos sobre tu FAMILIA:

**13. ¿Con cuántas personas vives en tu casa, incluyéndote?** _____

**14. Indica el número de hijos y/o hijas que tienes en total:** _____

**15. ¿Tú o alguna persona en tu casa ocupa o ha ocupado un puesto especial en tu comunidad? (autoridades civiles o educativas, fiscal, mayordomo, vocal)** ☐ Si ☐ No

## Ahora nos gustaría hablar de tu SALUD:

**16. Si tú o algún familiar tuyo estuvieran mal de salud, ¿cuál sería el primer lugar al que irían a pedir ayuda?**

1 ☐ Curandero o Huesero
2 ☐ Médico privado
3 ☐ Clínica de salud
4 ☐ Hospital público
5 ☐ Hospital privado
6 ☐ Otro (¿cuál?) _____

**17. Pensando en tu experiencia en general, ¿qué tan satisfecho estás con los servicios de salud que recibes en la clínica de salud?**

1 ☐ Muy insatisfecho
2 ☐ Insatisfecho
3 ☐ Ni satisfecho ni insatisfecho
4 ☐ Satisfecho
5 ☐ Muy satisfecho

**18. ¿Qué es lo que te preocupa de venir a la clínica de salud a que te atiendan?**

1 ☐ Distancia de tu casa
2 ☐ Calidad del trato de los médicos
3 ☐ Falta de medicamentos
4 ☐ Costos económicos
5 ☐ Calidad de los médicos
6 ☐ Tiempo de espera
7 ☐ Otro _____

**Finalmente te preguntaremos sobre cómo te va ECONÓMICAMENTE:**

**19. Indica si en tu casa tienes alguno de los siguientes bienes:**

1 ☐ Gallinas, Guajolotes
2 ☐ Caballos, vacas, cerdos
3 ☐ Letrina
4 ☐ Baño
5 ☐ Radio
6 ☐ Televisión
7 ☐ Teléfono celular
8 ☐ Teléfono fijo
9 ☐ Estufa eléctrica o de gas
10 ☐ Refrigerador
11 ☐ Lavadora
12 ☐ Computadora
13 ☐ Bicicleta
14 ☐ Automóvil o Camioneta
15 ☐ Tierra para cultivar

**20. El agua que usan en tu casa normalmente viene de:**

1 ☐ Agua entubada (potable) dentro de tu casa
2 ☐ Agua entubada o potable de tu vecino (te comparte)
3 ☐ No usan agua entubada (por ejemplo, traen agua de la presa o rio)

**21. El combustible que más usas para cocinar es:**

1 ☐ Carbón
2 ☐ Leña
3 ☐ Gas or Electricidad

**22. De qué material es la mayor parte de las PAREDES de tu casa:**

1 ☐ Material de desecho
2 ☐ Lámina de cartón
3 ☐ Lámina metálica
4 ☐ Lámina de asbesto
5 ☐ Bambú
6 ☐ Madera
7 ☐ Block, tabique, ladrillo, cemento, concreto o piedra.

**23. De qué material es la mayor parte del PISO de tu casa:**

1 ☐ Tierra
2 ☐ Cemento o piso firme
3 ☐ Madera, mosaico u otro recubrimiento

**24. De qué material es la mayor parte del TECHO de tu casa**

1 ☐ Material de desecho
2 ☐ Lámina de cartón
3 ☐ Lámina de metal
4 ☐ Lámina de asbesto
5 ☐ Teja o madera
6 ☐ Block, tabique, ladrillo, concreto

**25. ¿Cómo te ha ido económicamente en el último año?**

1 ☐ Muy mal
2 ☐ Mal
3 ☐ Más o menos
4 ☐ Bien
5 ☐ Muy bien

**26. ¿Cómo te va económicamente hoy comparado con antes de que entraras al programa Oportunidades?**

1 ☐ Mucho peor
2 ☐ Peor
3 ☐ Igual
4 ☐ Mejor
5 ☐ Mucho mejor

# Appendix F. Ethics committee approval

**ETHICS APPROVAL FORM 2012-13**

This document comprises pages 1 and 2 both of which must be competed in full.

You must then attach:

- page 3 - a summary of the research proposal (including full referencing, if cited)
- page 4 - a series of headings from the Ethics Checklist below that have been ticked as noted, each heading being followed by a brief paragraph on how any issues have been addressed.

You should use A4 paper, 12pt type and normal margins.

If you are conducting research on a placement or in association with another body where ethical approval has to be granted through a professional body, for example the NHS, or another University department, it is sufficient to append only the first two pages to the front of the ethical approval granted by the other body.

In all other cases, ALL research must meet the Department's Ethics Committee requirements. To do this, consult your Department's guidance.

You should pass a draft copy of your completed ethics form to your lead supervisor for discussion before submitting a final copy to him/her. Once the form is ready and signed by you both, you should pass the form to the Department's Ethics Officer for his approval. The Ethics Officer for SPS is Professor Ian Butler and you may email him the form direct or pass him a signed hard copy. Once his approval has been obtained, you should submit the form to the PGR administrator for your file (either the signed hard copy or electronically with an email trail with each level of approval recorded).

**Note**
**1. You should not begin work on your research until this approval is obtained**
**2. You are required to submit the signed off ethics approval form along with the other documentation required for the transfer to (or confirmation of) PhD status.**

**Ethics Checklist**

| Issue | Noted | Not applicable |
|---|---|---|
| A justification for the research | X | |
| Avoidance of deception, presentation of purpose of study | X | |
| Arrangements for debriefing, including access to support | X | |
| Obtaining consent, including right to withdraw | X | |
| Avoidance of distress or threats to self-esteem | X | |
| Privacy and confidentiality | X | |
| Special circumstances (eg respondents who cannot give consent, children under 16, unusual issues around privacy) | | X |
| Additional general ethical issues | X | |

ETHICS APPROVAL FORM 2012-13

**STUDENT TO COMPLETE**

Student name (please print): .....Viviana Ramirez.....

Email: ...vr231@bath.ac.uk..... Tel: ...07775505105.....

Programme: MPhil/PhD, Department of Social & Policy Sciences

**I hereby confirm that this document represents an accurate record of my proposed research.**

Student's signature: ..... Date: 05/11/2012

**STAFF MEMBERS TO COMPLETE**

You must show your supervisor your completed ethics form and obtain their agreement (evidenced through their signature below) that your proposal is of an appropriate academic standard to be forwarded to the Departmental Ethics Committee. Once your supervisor has signed off the ethics form, it should be passed to the Ethics Officer for his approval.

**Supervisor**

**I hereby confirm that this proposal is of an appropriate academic standard to be forwarded to the Departmental Ethics Committee.**

Supervisor name: .....Sarah C. White.....

Supervisor signature: .....Sarah C. White..... Date: 8/11/2012

**Ethics Officer**

**I hereby confirm that this proposal is of an appropriate academic standard and is approved by the Departmental Ethics Committee.**

Ethics Officer name: ...Professor Ian Butler.....

Ethics Officer signature: ..... Date: 9 November 2012

Please don't forget to append page 3 and 4 in line with the guidance provided on page 1 before passing ethics form to supervisor and ethics officer.

# Appendix G. IWB item correlations

IWB item correlations

| | CR1 | CR2 | CR3 | CR4 | CR6 | VM1 | VM3 | VM4 | VM5 |
|---|---|---|---|---|---|---|---|---|---|
| CR1 | 1 | | | | | | | | |
| CR2 | .259** | 1 | | | | | | | |
| CR3 | .336** | .417** | 1 | | | | | | |
| CR4 | .368** | .305** | .515** | 1 | | | | | |
| CR6 | .276** | .387** | .402** | .375** | 1 | | | | |
| VM1 | .238** | .343** | .281** | .257** | .326** | 1 | | | |
| VM3 | .151** | .301** | .251** | .246** | .175** | .342** | 1 | | |
| VM4 | .132* | .312** | .263** | .307** | .190** | .311** | .407** | 1 | |
| VM5 | .148** | .313** | .288** | .295** | .189** | .364** | .423** | .514** | 1 |
| SC1 | .319** | .234** | .195** | .194** | .180** | .241** | .082 | .159** | .083 |
| SC2 | .300** | .223** | .229** | .235** | .292** | .252** | .029 | .112* | .164** |
| SC3 | .163** | .155** | .131* | .132* | .040 | .130* | .061 | .165** | .101† |
| SC4 | .257** | .164** | .174** | .193** | .154** | .208** | -.053 | .127* | .068 |
| PMH1 | .250** | .281** | .273** | .221** | .179** | .200** | .150** | .222** | .206** |
| PMH2 | .129* | .163** | .154** | .239** | .127* | .043 | .066 | .156** | .045 |
| PMH3 | .150** | .212** | .208** | .200** | .272** | .188** | .127* | .191** | .149** |
| EC5 | -.037 | .057 | .172** | .083 | .088 | .016 | .021 | .088 | .001 |
| CSW1 | .094† | .085 | .069 | 0.098† | .127* | .121* | -.020 | .060 | .111† |
| CSW2 | .149** | .209** | .187** | .145* | .251** | .185** | .234** | .163** | .233** |
| CSW3 | .128* | .193** | .191** | .234** | .230** | .289** | .221** | .228** | .224** |
| CSW4 | .044 | .261** | .279** | .192** | .182** | .160** | .149** | .206** | .221** |
| CSW5 | .029 | .201** | .241** | .216** | .117* | .145* | .233** | .170** | .302** |
| EC1 | .031 | .222** | .227** | .206** | .118* | .215** | .178** | .176** | .242** |
| EC2 | .029 | .027 | .042 | .055 | .099† | .125* | .073 | .062 | .047 |
| EC4 | .129* | .102† | .144* | .192** | -.011 | .019 | .033 | 0.106† | .072 |
| AP1 | .160** | .140* | .074 | .043 | .079 | .141* | -.024 | .046 | .037 |
| AP2 | .084 | .052 | .060 | .009 | .126* | .017 | .003 | -.010 | .144* |

Pearson correlations, ** p<0.01, * p<0.05, † p-value<0.1

IWB item correlations (cont.)

| | SC1 | SC2 | SC3 | SC4 | PMH1 | PMH2 | PMH3 | EC5 | CSW1 |
|---|---|---|---|---|---|---|---|---|---|
| SC1 | 1 | | | | | | | | |
| SC2 | .442** | 1 | | | | | | | |
| SC3 | .162** | .267** | 1 | | | | | | |
| SC4 | .199** | .291** | .269** | 1 | | | | | |
| PMH1 | .202** | .227** | .145* | .214** | 1 | | | | |
| PMH2 | .117* | .072 | .159** | .188** | .256** | 1 | | | |
| PMH3 | .187** | .176** | .124* | .191** | .329** | .339** | 1 | | |
| EC5 | .088 | .085 | .025 | .069 | .083 | .323** | .321** | 1 | |
| CSW1 | .178** | .138* | .033 | .239** | .093 | .049 | .060 | -.026 | 1 |
| CSW2 | .159** | .158** | .110† | .154** | .212** | .077 | .093 | .024 | .282** |
| CSW3 | .161** | .100† | .150** | .109† | .148** | .000 | .069 | -.065 | .239** |
| CSW4 | .119* | .194** | .156** | .088 | .164** | .278** | .256** | .198** | .012 |
| CSW5 | .093 | .183** | .002 | .030 | .092 | .171** | .139* | .131* | -.058 |
| EC1 | .074 | .077 | .007 | 0.108† | .134* | .141* | .147** | .210** | -.034 |
| EC2 | .161** | .109† | .147** | .145* | .053 | .046 | .185** | .216** | -.011 |
| EC4 | .111† | .248** | .116* | .154** | .152** | .120* | .181** | .244** | -.034 |
| AP1 | .253** | .242** | .072 | .214** | .001 | -.064 | .037 | -.064 | .224** |
| AP2 | .167** | .095 | -.002 | .042 | .005 | -.014 | -.029 | -.13* | .085 |

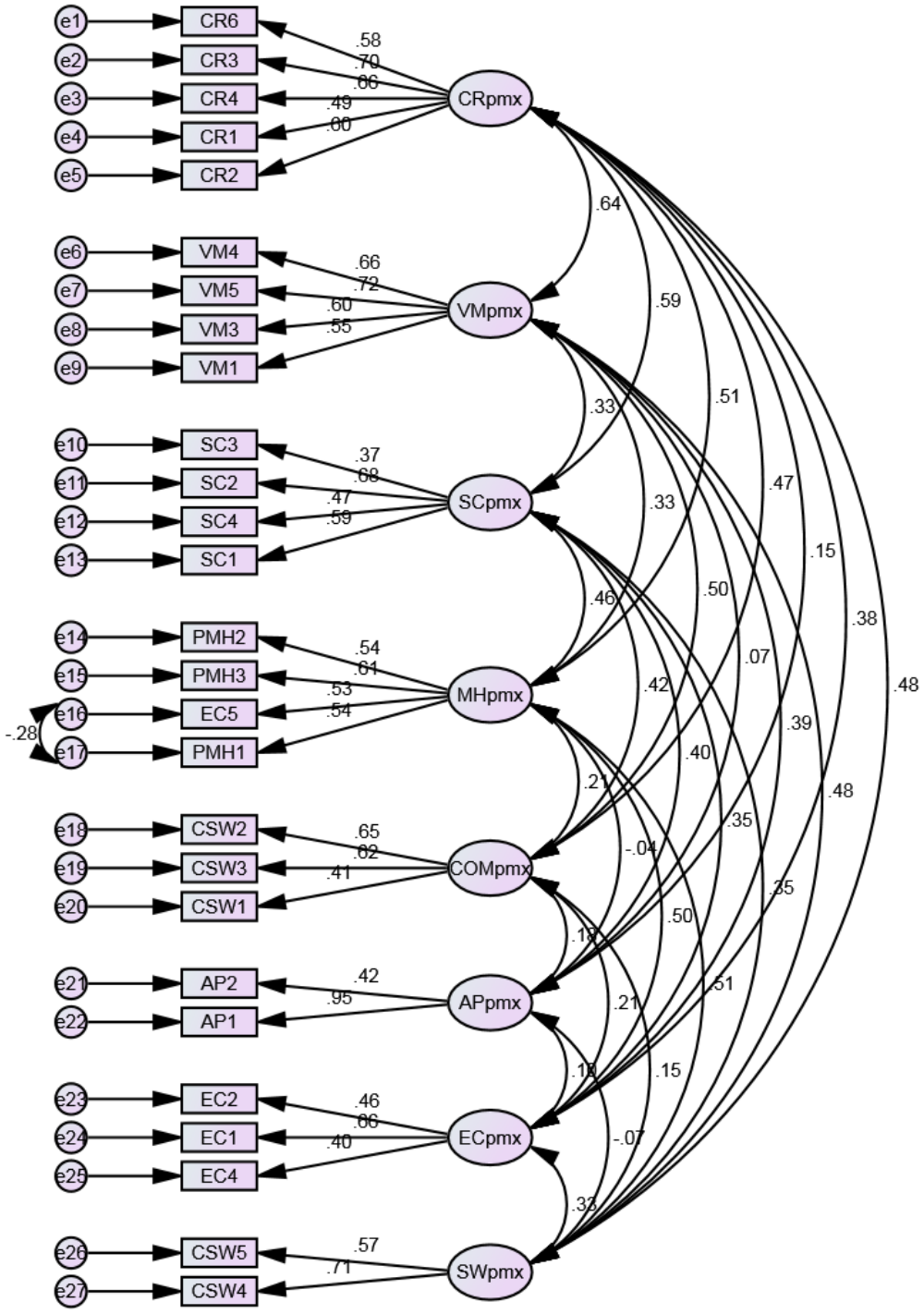
Pearson correlations, ** p < 0.01, * p < 0.05, † p-value < 0.1

IWB item correlations (cont.)

| | | CSW3 | CSW4 | CSW5 | EC1 | EC2 | EC4 | AP1 | AP2 |
|---|---|---|---|---|---|---|---|---|---|
| CSW2 | 1 | | | | | | | | |
| CSW3 | .406** | 1 | | | | | | | |
| CSW4 | .033 | .104† | 1 | | | | | | |
| CSW5 | .053 | .129* | .404** | 1 | | | | | |
| EC1 | .083 | .081 | .170** | .219** | 1 | | | | |
| EC2 | .110† | . 208** | -.038 | .019 | .335** | 1 | | | |
| EC4 | .038 | .016 | .104† | .113* | .241** | .150** | 1 | | |
| AP1 | .080 | .069 | -.072 | .006 | .055 | .081 | .023 | 1 | |
| AP2 | .038 | .059 | -.025 | .084 | -.062 | .041 | -.028 | .401** | 1 |

Pearson correlations, ** p < 0.01, * p < 0.05, † p-value < 0.1

Appendix H. IWB Confirmatory Factor Analysis model



# Appendix I. QoR Confirmatory Factor Analysis model